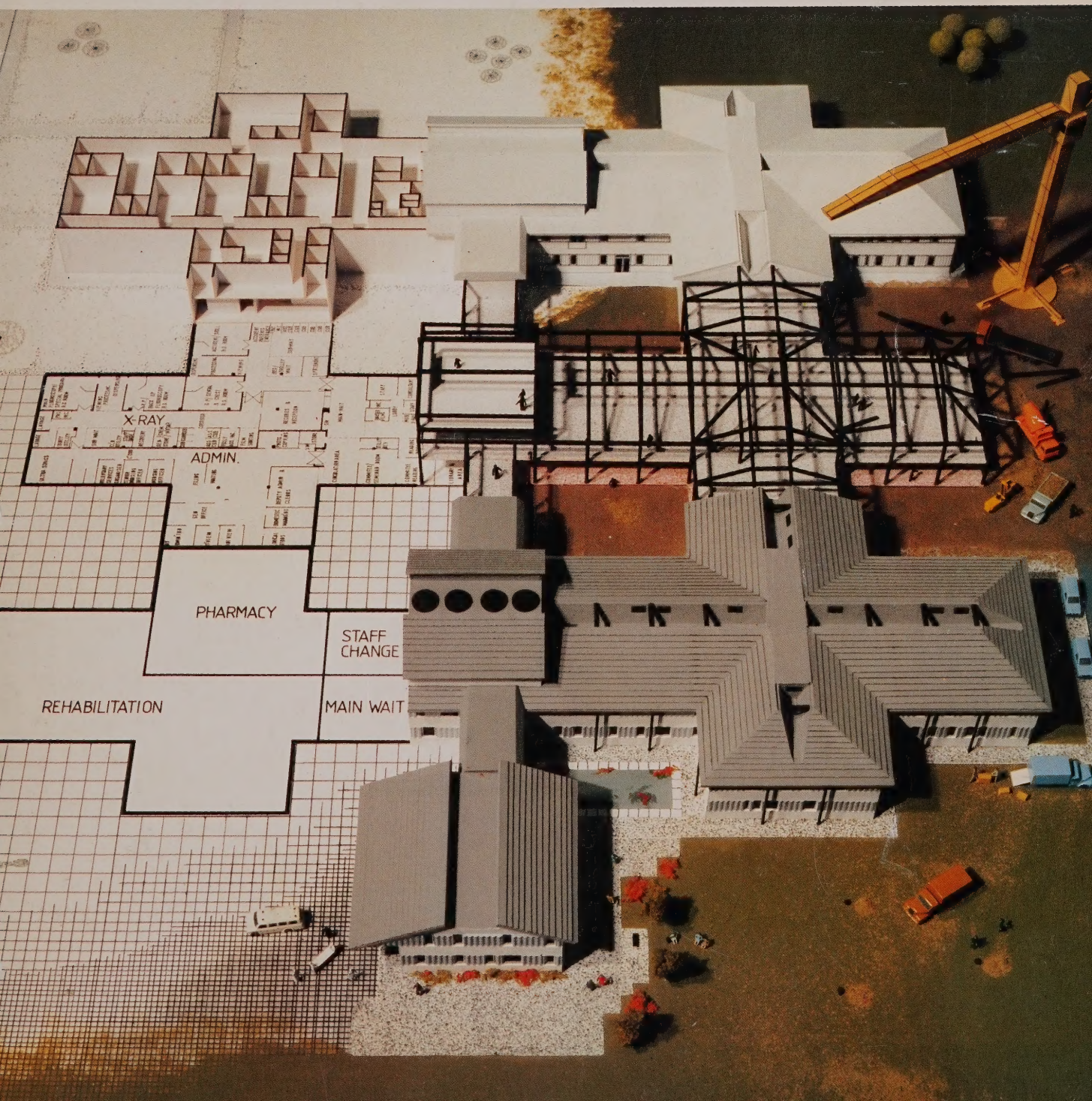
MC0334

Department of Health and Social Security

CAPRICODE

Health Building Procedures

LONDON HER MAJESTY'S STATIONERY OFFICE



The cover illustration shows a schematic representation of Maidstone District General Hospital. Architects Powell, Moya and Partners. Client S.E. Thames Regional Health Authority.

Department of Health and Social Security

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London Her Majesty's Stationery Office

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CAPRICODE CONTENTS

	Para(s)	Page
INTRODUCTION		
General	1-4	1
Health Authorities' Responsibilities and Public Accountability	5-8	2
Scheme Management	9	2
Appraisal/Project Team Membership	10	2
Review of Schemes and Programmes	11	3
The Estate	12	3
Small Schemes	13	3
Nucleus	14	3
CONCODE	15	3
CONCISE	16	3
CHAPTER 1: STAGE 1: APPROVAL IN PRINCIPLE		
General Notes	1.1-1.2	4
Option Appraisal	1.3-1.10	4
Approval in Principle Submission	1.11-1.13	5
Consultation	1.14-1.16	6
CONCISE	1.17-1.18	6
Procedures	1.19	6
Annex 1A: Approval in Principle Submission		7
Annex 1B: Option Appraisal Framework		9
Annex 1C: Scheme Description		12
Cost Form 1 - Capital Costs Summary		15
Cost Form 2 - Departmental Cost and Equipment Cost		16
Cost Form 3 - On-Costs		17
Cost Form 4 - Fees and Other Costs		18
Cost Form 5 - Revenue Costs		19
Annex 1D: Capricode Information Sheet: CONCISE 1		20
Annex 1E: Procedural Stages: Approval In Principle		21
CHAPTER 2: STAGE 2: BUDGET COST		
General Notes	2.1-2.4	23
Readiness to Proceed to Design	2.5	23
Capital Costs	2.6-2.8	23
Revenue	2.9	24
Review of Options	2.10-2.11	24
Procurement Method	2.12	24
Budget Cost Submission	2.13-2.14	24
CONCISE	2.15	25
Procedures	2.16	25
Annex 2A: Budget Cost Submission		26
Annex 2B: Certificate of Readiness to Proceed to Design		28
Annex 2C: Procedural Stages: Budget Cost		29

CAPRICODE - CONTENTS

	Para(s)	Page
CHAPTER 3: STAGE 3: DESIGN		
General Note	3.1	32
Design Brief	3.2	32
Readiness to Proceed to Design	3.3	32
Planning Permission and Consultation	3.4-3.5	32
Land Transactions	3.6	32
Scheme Management	3.7 - 3.8	33
Design Development	3.9	33
Design Certification	3.10 - 3.11	33
Readiness to Proceed to Tender	3.12	33
CONCISE	3.13	33
Procedures	3.14	34
Annex 3A: Certificate of Readiness to Proceed to Tender		35
Annex 3B: Procedural Stages: Design		36
CHAPTER 4: STAGE 4: TENDER AND CONTRACT		
General Note	4.1	40
Tendering/Contracting Arrangements	4.2-4.6	40
Selection of Contractors	4.7	40
Requirements of EC Directives	4.8	40
Tender and Contract	4.9-4.10	41
Contract Period	4.11-4.12	41
Approved Sum	4.13-4.15	41
Cost Analysis of Tender	4.16	42
CONCISE	4.17	42
Procedures	4.18	42
Annex 4A: Procedural Stages: Tender		43
CHAPTER 5: STAGE 5: CONSTRUCTION		
General Note	5.1	45
Contract Administration	5.2	45
Contract Monitoring and Control	5.3-5.5	45
Approved Sum	5.6-5.9	45
Variations	5.10-5.11	46
Contingency Sums	5.12-5.13	46
Dealing with Delay and Cost Escalation	5.14-5.17	47
Contractors' Claims	5.18-5.20	47
Contract Payments	5.21	47
Final Account	5.22-5.24	48
Special Payments	5.25	48
Design Certification on Completion	5.26-5.27	48
Procedures	5.28	48
Annex 5A: Capricode Contract Report: CONCISE 2		49
Annex 5B: Procedural Stages: Construction		50

CAPRICODE - CONTENTS

	Para(s)	Page
CHAPTER 6: STAGE 6: COMMISSIONING		
General Notes	6.1-6.3	51
Commissioning Team	6.4	51
Commissioning Brief	6.5-6.8	51
Operational Systems	6.10-6.13	52
Manpower	6.14	52
Support Services	6.15	52
Building Handover	6.16-6.19	53
Procedures	6.20	53
Annex 6A: Procedural Stages: Commissioning		54
CHAPTER 7: STAGE 7: EVALUATION		
General Note	7.1	57
Process and Aims	7.2	57
Evaluation during Scheme Development	7.3	57
Evaluation of Scheme in Operation	7.4	57
Procedures	7.5	57
Annex 7A: Procedural Stages: Evaluation		58
APPENDICES		
Appendix 1: Summary of Capricode Stages		59
Appendix 2: Schemes Shared with the UGC/Universities		60
Appendix 3: Glossary		61
Appendix 4: Abbreviations		67

INTRODUCTION

General

1. Capricode provides the mandatory procedural framework for managing and processing NHS capital building schemes, including schemes funded centrally by the Department and schemes partly funded from other sources such as the University Grants Committee, trust funds or private donations. Regional Health Authorities, District Health Authorities and Special Health Authorities must plan and execute their schemes according to Capricode, their own internal procedures, Standing Orders/ Instructions and scheme documentation must be based on Capricode principles and procedures. The Capricode procedural framework is independent of particular systems of monitoring and control and such systems may be varied from time to time without affecting the requirement to progress schemes according to Capricode stages. Special circumstances on individual schemes may justify tighter controls than Capricode prescribes; health authorities and the Department, within the framework of Capricode, may adopt, or require the application of, particular controls or systems of control where they consider it justified.

2. The procedures reflect the logical sequence of events necessary to progress health building schemes from inception to completion and commissioning. They provide for clear timetabling and effective management of schemes and the ongoing monitoring and evaluation of performance. Their aim is to secure a sound, consistent and accountable approach by health authorities and to promote health building schemes which, give best value for money (in terms of both capital and running costs), accommodate the requisite services efficiently, open on time, and keep within budget. Adherence to Capricode and presentation of submissions and information in the required form at the right time will assist the management, processing and audit of schemes, thereby promoting timely decision-making, approvals and reporting. The procedures themselves cannot guarantee successful health building, it is the commitment of management, Appraisal Teams, Project Teams and Design Teams that produces the results the procedures seek.

3. Capricode procedures do not cover fully the detailed day to day activities of those primarily responsible for the planning, design and execution of schemes. Similarly Capricode does not relieve consultants of their responsibilities arising from the terms and conditions of their engagement or from their duties under the conditions of contract. However, consultants will find Capricode a useful reference for the basic information required by health authorities as work progresses, and for the standard of management and control expected. Provided health authorities comply with Capricode procedures they may implement their own detailed arrangements for processing and controlling schemes. Consultants should refer to their client health authority for precise requirements and instructions.

4. The procedures comprise a series of interconnected stages as follows:

Stage 1: Approval in Principle (AIP)
Stage 2: Budget Cost
Stage 3: Design
Stage 4: Tender and Contract
Stage 5: Construction
Stage 6: Commissioning
Stage 7: Evaluation

A summary of procedures and sub-stages is included at Appendix 1. Some overlapping of the procedural stages may be necessary to provide the information needed at various decision making points but the key decisions themselves should be taken in the sequence required by Capricode. Care should be taken not to enter prematurely into commitments which pre-empt decisions that ought properly to be taken at a later stage, nor should more work be carried out at each stage than is necessary to reach decisions in the sequence required.

Health Authorities' Responsibilities and Public Accountability

5. The Secretary of State for Social Services, in accordance with the NHS Act 1977, as amended by the Health Services Act 1980, and the National Health Service Functions (Directions to Authorities and Administration Arrangements) Regulations 1982 (SI 1982 No. 287), has delegated his duties to provide hospitals and other National Health Service accommodation to Regional Health Authorities and through them to District Health Authorities, subject to such limitations as may be specified and in accordance with any directions the Secretary of State may give.

6. Directions were given under previous legislation in DS letter 40/74 dated 6 March 1974. These Directions continue to apply to authorities, including District Health Authorities after 1 April 1982 by virtue of Article 15(1) of the National Health Service (Determination of Districts) Order 1981. Further Directions were made and issued on 30 March 1982 to provide that the Special Health Authorities for the London Post-Graduate Teaching Hospitals must follow procedures and instructions similar to those applying to District Health Authorities. Additionally, the procedures apply to any schemes by any other Special Health Authorities as well as to any non-health authority schemes funded by the Department.

7. Health authorities' building schemes are financed mainly from public funds voted by Parliament. Health authorities have a general duty to secure best value for money and must conform to Government policies on scheme planning, procurement and cost control. Capricode procedures provide for the necessary control and reporting on schemes and enable those accountable for the expenditure of public money to explain whether resources have been spent efficiently and economically for the purposes voted by Parliament. Explanations may be required by the Comptroller and Auditor General (C&AG) and by the House of Commons Committee of Public Accounts (PAC) following reports to Parliament by the C&AG. PAC may require relatively detailed information on individual building schemes. Adherence to Capricode ensures that much of the information required for explanatory/accountability purposes is readily available from the basic documentation of schemes, hence detailed ad hoc inquiries may be avoided.

8. Health authorities must operate approval, monitoring and control systems for the management of schemes that are compatible with Capricode. Such systems must be documented to facilitate audit and assessment of their performance and effectiveness in use. Decision making, including Capricode approvals, may be delegated to senior officers. The delegated powers of senior officers and the framework, including Standing Orders/Instructions, within which such powers are exercised must be clearly defined. Systems for reporting on approvals given and the progress of schemes, including the position on costs, must be rigorously applied.

Scheme Management

9. Responsibility for management of the planning and execution of each scheme should be vested in an individual officer, the Project Manager, who should be accountable for adherence to Capricode procedures and keeping the scheme to timetable and budget.

Appraisal/Project Team Membership

10. Team membership should be limited to the essential contributors needed at relevant stages. The composition of teams should be reviewed on completion of each Capricode stage and, if necessary, membership re-cast to reflect the work and activities of the next stage.

Review of Schemes and Programmes

11. The progress of schemes must be reviewed regularly (at least quarterly) by senior health authority management throughout Capricode Stages 1 to 6 inclusive. Where appropriate such reviews should be conducted on a joint RHA/DHA basis. Reviews should be based on reports from Appraisal/Project Teams covering progress, cost and other key aspects as planning proceeds and the scheme moves through Capricode stages. Where delays and problems are occurring or local circumstances require a revision of the scheme timetable (e.g. because of a change in priority), management action should be taken and adjustments to the scheme timetable and, if necessary, to the overall capital programme should be made.

The Estate

12. The estate is a key resource and health authorities are required to regulate their property holdings to match the demand for patient services as identified in strategic plans. Guidance on estate rationalisation may be found in Estatecode.

Small Schemes

13. For small, simple capital building schemes, including purchase and installation of a particular item of plant or equipment, it may not be sensible or cost effective to go into great detail in applying approval, monitoring and control procedures. It is important, however, that the Capricode processes are followed to the degree and the extent necessary to satisfy public accountability and expenditure control, and to ensure that schemes are compatible with the agreed strategy and Development Control Plans. Cost cannot always be taken as the determining factor and complexities in relatively low cost schemes will demand detailed observance of Capricode procedures. RHAs should determine with their DHAs a realistic capital cost level above which full and detailed operation of procedures will apply in all cases. SHAs should consult with the Department on arrangements for the identification of small schemes.

Nucleus

14. Nucleus is a system for hospital planning and design. Supported by comprehensive information, including standardised briefing material and planning documentation, the system promotes cost improvement and streamlines the development and processing of schemes through Capricode stages. Nucleus documentation and data are available to health authorities from the Department.

CONCODE

15. References are made to CONCODE which contains guidance to health authorities on the procurement of NHS building and engineering work in Part I and on the commissioning of consultants in Part II. It is not on general sale and is issued only to health authorities. Health authorities must ensure that consultants working to Capricode procedures are made aware of the relevant CONCODE guidance.

CONCISE

16. CONCISE (Computerised National Capital Intelligence Service and Exchange) is the computer based integrated health buildings information system used by health authorities and the Department to assist the management and planning of schemes.

Stage 1: APPROVAL IN PRINCIPLE

General Notes

1.1 Any decision to commit resources to a capital development must be based on a clear statement of agreed strategy and priorities for health care services, a clear definition of service/development objectives, an explicit appraisal of options and an explanation of funding arrangements. Health authorities should not allow time to be devoted to detailed scheme planning and building design until they have seen and approved an Approval in Principle (AIP) Submission based on an appraisal of options.

1.2 Stage 1 AIP procedures are designed to assist members of health authorities play an active part in capital investment decisions through the clear and straightforward presentation of information about development alternatives.

Option Appraisal

1.3 Option appraisal is an integral part of the planning and development continuum and is used at all stages to provide managers with the information necessary to ensure that best value for money is obtained from all decisions; for example, option appraisal has a general role in assisting the preparation of Strategic Plans. As planning moves from policy to implementation, it becomes necessary to explore broad strategic intentions and particular service and performance objectives in more detail by considering alternative ways of implementing strategy and achieving objectives. No proposal for capital investment may proceed to AIP without a formal option appraisal which promotes full and informed consideration of the alternatives available, taking account of opportunities for improvements in patient services, use of resources (including the estate) and costs. A framework for option appraisal is included at Annex 1B.

1.4 Option appraisal itself has a cost. The scale of the appraisal should be tailored to the size and the importance of the development proposed; its scope will be determined by the objectives. For example, for small schemes option appraisal may be carried out within the context of health authorities' agreed programmes of minor works/equipment procurement (the programmes themselves having been selected following option appraisal) to confirm that particular investments continue to represent best value for money. Development proposals relating to the disposition of a range of patient services covering several possible sites may require a relatively detailed appraisal to discriminate between options. For large complex developments a full option appraisal for AIP purposes should not be undertaken without prior authorisation from the health authority.

1.5 In some circumstances the preferred option may comprise several building schemes separated over time (e.g. a project comprising several schemes); each scheme will require an AIP Submission in its own right. Investment in the initial scheme of a project will influence strongly the pattern of further development by inhibiting the opportunity for a future change of direction. In such cases it is particularly important to test for uncertainty to determine the viability of schemes, particularly how robust and secure successive schemes would be in the face of changed circumstances. Where option appraisal supports a number of AIP Submissions, succeeding submissions will need to take account of any significant changes in circumstances such as a shift in the demand for services, improvements in service practice and/or the emergence of new options.

1.6 Normally, for large complex developments, option appraisal and the preparation of the AIP Submission will be carried out by a mulitdisciplinary Appraisal Team. Membership should reflect the interests of those managing and operating services and administering assets and resources. Responsibility for the management of Stage 1 work should be clearly vested in an individual who should be accountable to health authority management for co-ordinating and maintaining the programme of work, and completing the option appraisal and the AIP Submis-

sion according to timetable. The Project Team, established following AIP, should have some members drawn from the Appraisal Team to ensure continuity.

1.7 The initial selection of options is an important step in the appraisal process as ultimately an appraisal will be invalidated if relevant options have not been considered. The Appraisal Team should liaise with the authority responsible for final AIP during option appraisal and the preparation of the AIP Submission; options considered, the progress of work and target dates for formal submission should be reported. Where the range of options is restricted the Appraisal Team may wish to make an interim report before completion of the appraisal. For example, options considered may be rejected after only limited scrutiny because freedom of action may be justifiably constrained by past events and only restricted choices are reasonably open to the health authority. However, past development and future aspirations for sites should not constrain unnecessarily the range of options considered at the outset. Where choice of the preferred option is a matter of fine judgement or likely to be controversial the Appraisal Team may wish to make an interim report before preparation of the AIP Submission. It is important that the arguments for a particular course of action are clearly explained. Rejected options must be reported in the AIP Submission together with reasons for the rejection.

1.8 Proposals for certain types of capital investment must be subject to explicit appraisal within the main option appraisal. These include support services, such as catering and laundry, and staff residential accommodation (excluding on-call accommodation integral with the main development). Such proposals must be identified and described in AIP Submissions. Normally they will be considered and approved separately from other aspects of development.

1.9 In all appropriate cases, health authorities must consider the Nucleus system as an option for the planning and design of health building schemes. Where use of Nucleus is rejected at Stage 1, a general description of the alternative building solution proposed and clear justification for the rejection of Nucleus based on service and site considerations should be included in the AIP Submission.

1.10 Where option appraisal results in the selection of changes in services/operations not involving capital expenditure, Capricode procedures no longer apply. However, health authorities must implement such "non-capital" options with due regard for efficiency, economy and the availability of revenue resources. They must consult and seek approvals (e.g. to closures or changes of use of buildings) as necessary.

Approval in Principle Submission

1.11 AIP Submissions should provide information in the general form outlined in Annex 1A, adapted as necessary, to reflect clearly the various factors which determine the choice of option. The option appraisal report and detailed scheme description should be appended.

1.12 Approved schemes must;

(a) meet up-to-date and agreed strategy for development of health care services and main objectives,

(b) offer best value for money,

(c) be compatible with an updated and agreed Development Control Plan, and

(d) be capable of implementation within expected future revenue and capital budgets.

1.13 Proposals for developments selected for specific and separate option appraisal as mentioned at paragraph 1.8 (e.g. catering, laundry, staff residential accommodation) must be identified clearly and described separately in the AIP Submission.

Consultation

1.14 All major development must be the subject of appropriate professional and public consultation at local level before a formal AIP Submission is made to the health authority or the Department. Health authorities have a statutory duty to ensure that local Community Health Councils (CHC) are consulted on any proposals for substantial development or variations in service including new developments and replacement facilities.

1.15 Organisations such as local authorities (and especially in their capacity as social services, planning and highway authorities), local transport authorities, family practitioner committees, public utilities and voluntary organisations who are likely to be affected by the development should be consulted. Health authorities must consult with the relevant university on all proposed teaching hospital schemes.

1.16 During the process of consultation and obtaining Approval in Principle it is important that capital investment in new and improved facilities, together with any consequent closures, is considered and presented as part of a coherent and viable pattern of service development. In some cases it will be sensible to combine the formal closure consultation required by HSC(IS)207 with the consultation on the package of changes which include the new scheme. Even where formal consultation is reserved to a later stage, it will make sense at this earlier stage to seek the CHC's agreement in principle to any closure that is part of the package of changes in provision. If the closure is subsequently contested by the CHC and Ministers are asked to decide whether it should happen, they should be informed of the views and/or comments made by the CHC during the process of consultation on the AIP, and the reasons for any change of view.

CONCISE

1.17 During Stage 1, a "Capricode Information Sheet: CONCISE 1" (Annex 1D) must be initiated for all schemes with a Works Cost over £1 million. The information is recorded by the Department on the CONCISE computerised health buildings information system and used for monitoring schemes and reporting on the NHS capital programme. The Information Sheets will be capable of only partial completion at Stage 1. Subsequent stages provide for their updating as more details on progress, costs, consultants, contractors etc. become available. "Capricode Information Sheets: CONCISE 1" may be completed for small schemes at health authorities' discretion.

1.18 CONCISE 1 computer programs available from the Department may be used by health authorities to record and monitor their own schemes irrespective of size.

Procedures

1.19 The procedural stages up to and including approval to proceed to Stage 2 are outlined in Annex 1E.

THE APPROVAL IN PRINCIPLE SUBMISSION

1. STRUCTURE

AIP Submissions must be presented in the following form:

a. Summary of option appraisal
b. Scheme outline
c. Detailed option appraisal report (Annex 1B)
d. Scheme description (Annex 1C)
e. Supplementary information (where appropriate)

The information in individual submissions should be consistent with the size and the importance of the investment proposed.

2. SUMMARY OF OPTION APPRAISAL

Briefly describe main aspects of option appraisal including:

Strategic Planning Context

a. Describe present services and resources currently used (capital/estate and revenue) and explain why development is considered necessary.

b. Indicate assessed potential for achieving improvements in services and performance, including savings and better use of resources, as highlighted in Strategic Plans and through Regional/District Reviews.

c. Indicate any special factors influencing need or priority.

d. Justify assessment of services and functions required by reference to present and future catchment populations, the expected demand for services (significant cross-boundary flows must be agreed with adjacent health authorities), present service activity, and planning targets for provision of beds etc.

Objectives Constraints and Performance Criteria

e. State service/development objectives.

f. State verifiable performance criteria for main objectives.

N.B. *The foregoing sections may be based on extracts from Strategic Plans updated as appropriate.*

The Options

g. List and describe the options considered and give explicit reasons for the early rejection of options. Identify options selected for detailed analysis.

N.B. *Options may or may not involve capital development.*

Evaluation of Options

h. Generally describe extent of evaluation.

j. Highlight any marked differences between options in the value and timing of costs and benefits.

k. Give general description of preferred option and justify choice.

l. State nature and magnitude of any feasible changes which would signal a review or lapse of AIP, e.g. trigger values on AIP capital cost and AIP revenue cost (Annex 1C paragraphs 5d and 6e).

N.B. *AIP lapses automatically where increases in either AIP capital cost or AIP revenue cost exceed 10% in real terms.*

The detailed option appraisal report should be added to the submission.

3. SCHEME DESCRIPTION

a. Briefly describe main aspects of proposed scheme selected on the basis of option appraisal and for which AIP is sought.

b. Outline scope, give location, main contents, estimated capital costs and estimated annual running costs.

c. Further details should be added to the submission as indicated at Annex 1C.

4. APPENDICES

In addition to the option appraisal report and the scheme description, where appropriate, the following supplementary information should be added to the submission:

a. Map or plan showing location of scheme and relationship to existing facilities and other units, and proposals for estate development/rationalisation including any change of use.

b. Development Control Plan.

c. Results of local consultations.

d. District Profile for distribution of beds and facilities categorised by location and major specialty before and after proposed development.

OPTION APPRAISAL FRAMEWORK

1. GENERAL

The following steps illustrate the process of option appraisal. An option appraisal report should be structured accordingly. The steps should be used flexibly taking account of the scale and the importance of development proposals and the information needed to discriminate between options. Iteration within the process may be necessary, for example some evaluation will be necessary to shortlist options.

The aim is to provide managers with clear, relevant, well organised information to assist decision making.

2. STRATEGIC PLANNING CONTEXT

a. Identify service development priorities and priorities for improving use of resources as reviewed in Strategic Plans.

b. Prepare background information on changes in the pattern of services and use of resources (including the estate) required to implement strategy. Highlight improved use of resources.

c. Describe and quantify present catchment population, present level of service activity and resources used (including manpower and property). Quote relevant performance indicators and describe condition, functional suitability and utilisation of property.

d. Justify assessments of future services and functions required by reference to projected catchment population and expected demand for services.

e. Indicate any special factors influencing need or priority.

3. OBJECTIVES, CONSTRAINTS AND PERFORMANCE CRITERIA

a. Review performance of existing services and facilities to identify any surplus capacity and particular targets for improving efficiency and effectiveness.

b. Define performance criteria to be used to assess output of options and the achievement of objectives.

c. Establish clear objectives for future services in terms of health care outputs and use of resources.

d. Identify any key constraints (e.g timescale, available resources, location) which will affect all options. Avoid unnecessary constraints.

e. Objectives and constraints should be defined and, if possible, quantified to assist formulation and evaluation of options.

f. Identify any other particular features likely to assist evaluation.

4. FORMULATIONS OF OPTIONS

a. Identify alternatives for meeting objectives.

b. Give clear reasons for early rejection of options.

c. Specify options for detailed evaluation by reference to objectives, constraints and performance criteria.

d. Options may or may not involve capital investment.

5. EVALUATION OF OPTIONS

a. Identify, assess and compare extent and timing of costs and quantifiable financial benefits occurring over the functional life of options including:

i. Capital and revenue costs including, where appropriate, the value or cost of assets used. The opportunity cost of property (including land) already in NHS ownership should be included.

ii. Quantifiable financial benefits in the form of income, cost savings in other services, realisable assets etc.

iii. Significant costs and benefits occurring outside the NHS (may be shown separately).

iv. Use discounted values to assist comparisons.

N.B. *All costs and quantifiable financial benefits should be dated and reported at constant prices at a specified price level. The cost forms at Annex 1C may be used for assessing scheme costs and if necessary may be adapted for use in assessing project costs.*

b. Identify and describe all service benefits and outputs over the functional life of options using measured assessments where possible (e.g. throughput of patients). Project likely performance of options.

c. Identify and assess locational/siting aspects including accessibility.

d. Identify and assess effects on other patient services, other health authorities and other health care agencies e.g. local authority provision of personal social services, voluntary organisations, etc.

e. Explain any other factors which may affect choice including environmental impact (visual impact, traffic generation), manpower implications (recruitment, training), timing, etc.

f. Test for uncertainty, assess relative importance of particular estimates and assumptions to determine any feasible changes which could overturn the choice of option, and identify trigger values which initiate reappraisal of options.

6. SELECTION OF PREFERRED OPTIONS

Summarise and present results of evaluation to explain choice of option and identify likely improvements in patient services and performance. The option appraisal report should be annexed to the AIP Submission.

SCHEME DESCRIPTION

(to be annexed to the AIP Submission).

1. GENERAL

The main aspects of the scheme should be described to indicate impact on services and use of resources, and to provide a discipline for subsequent planning and design development.

Include the following information where appropriate.

2. CONTENT

a. Identify functional content and distribution of beds and services, indicate bed numbers/scale of provision, ad hoc departments, etc. (Cost Form 2 may be used).

b. Identify major specalities, in-patients, out-patients, day patients and short-stay facilities. (Cost Form 2 may be used).

c. Identify diagnostic and treatment services and other supporting services departments. (Cost Form 2 may be used).

d. Identify major engineering/environmental services and facilities.

e. Identify any content that depends on other schemes/phases for its viability.

f. List any teaching component (see Appendix 2).

N.B. *Where appropriate, departments should be expressed in terms of functional units as defined in the relevant Health Building Note or an indication of space requirements should be given.*

N.B. *Assessment* of functional content should take into a*ccount the output and capacity of functional departments as described in Health Building Notes. Levels of provision should be determined accordingly.*

N.B. *Proposals for development of staff residential accommodation and investment in facilities for selected support and ancillary services (catering and laundry) must be identified and justified separately in the submission.*

3. SERVICE IMPLICATIONS AND BENEFITS

a. State proposed changes to existing pattern of services and method of operations in the District/locality (including other DHAs/ SHAs if relevant) and describe likely benefits.

b. Identify proposed property closures, property sales and changes of use.

c. Indicate other changes necessary for the effective and efficient operation of services including any upgrading or adaptation of existing facilities.

d. Estimate expected throughput of patients in relation to capacity of functional departments.

e. Identify any objectives which are not expected to be achieved in full.

4. LOCATION, GENERAL SITING AND PROPOSED SOLUTION

a. Indicate location and general siting proposed for development.

b. Indicate building form and location of departments.

c. Identify relationships with existing services and other units.

d. Describe accessibility to catchment population.

e. Highlight possible impediments and constraints on development, e.g. planning considerations.

f. Describe and give reasons for proposed planning/building solution. Where Nucleus is not selected justify its rejection and explain reasons for proposed planning/design solution.

g. Outline implications for future use, development/rationalisation of the estate.

5. CAPITAL COSTS (Use Cost Form 1)

a. Report AIP capital cost, including departmental costs, reasonable on-costs (identifying main elements) and costs of fees and equipment.

b. Forecast annual incidence of capital expenditure and confirm that resources will be available within current resource assumptions.

c. State the base year prices used to calculate costs, give index level of pricing.

d. State percentage change in capital costs (measured in real terms) needed to trigger a review or lapse of AIP. Health authorities should normally expect values to be set within the range + 2½% to + 5%. In any case AIP will lapse if AIP capital cost increases in real terms by more than 10%.

6. RUNNING COSTS

a. Report AIP revenue cost (annual running costs based on full year of normal operation). Estimates should reflect staffing at (8) below and the known planning/design features.

b. State the base year prices used to calculate costs, give index level of pricing where appropriate.

c. State net saving or increase on overall revenue budget and confirm that resources will be available within current resource assumptions.

d. Identify source of any additional revenue funds required.

e. State percentage change in AIP revenue cost (measured in real terms) needed to trigger a review or lapse of AIP. Health authorities should normally expect trigger values to be set within the range + 2½% to + 5%. In any case AIP will lapse if AIP revenue cost increases in real terms by more than 10%.

7. TIMING

a. Outline programme for planning and development, identify target dates for completion of subsequent Capricode stages and date(s) when services to patients are expected to commence.

8. STAFFING

a. Report existing and estimated future staff complement and set out redeployment/recruitment implications (staffing costs should be reflected in (6) above).

9. OTHER CONSIDERATIONS

a. Report any significant consequences of scheme outside the NHS (cost or benefit).

b. Identify any expected participation of private firms, voluntary organisations, etc. in the provision and operation of services.

A statement showing breakdown and incidence of estimated capital and running costs, reported on Cost Forms 1,2,3,4, and 5, should be included as part of the scheme description. Where appropriate CONCISE 4 outputs may be used for reporting capital costs.

SCHEME ..... APPROVAL IN PRINCIPLE
BUDGET COST*

CAPITAL COSTS SUMMARY

Basis of estimating: QSSD tender price index level ..... (Base 19 = 100)*
: PIPSH tender price index level ..... (Base 19 = 100)*

1.	Departmental Cost (from Form 2)		£
2.	On-Costs (from Form 3) (% of Departmental Cost)		£
3.	Works Cost		£
4.	Equipment Cost (from Form 2) (% of Departmental Cost)		£
5.	Fees (from Form 4) (% of Works Cost)		£
6.	Other Costs (from Form 4)		£
7.	AIP COST/BUDGET COST*		£
8.	Proposed Contract Period		.....
9.	Forecast Capital Expenditure Profile	Year	Amount £

For use at Stage 1 and Stage 2
* Delete as appropriate.

SCHEME ..... APPROVAL IN PRINCIPLE
BUDGET COST*

CAPITAL COSTS: DEPARTMENTAL COST AND EQUIPMENT COST

Basis of estimating: QSSD tender price index level ..... (Base 19 = 100)*
: PIPSH tender price index level ..... (Base 19 = 100)*

Functional Content	Functional Units/Space Requirements	Accom-modation**	Cost Allowance***	Equipment Cost
			£	£
Departmental Cost and Equipment Cost to Summary (Form 1)			£	£

For use at Stage 1 and Stage 2
* Delete as appropriate.
** Indicate whether functions accommodated in new building (N), existing building adapted for change of use (A), or existing building retaining current use (C).
*** Must be based on or related to DHSS Cost Allowances.

N.B. *Identify separately any proposed additional capital expenditure (extra over cost allowances) to improve specific aspects of scheme performance, e.g. energy saving measures.*

SCHEME ..... APPROVAL IN PRINCIPLE BUDGET COST*

CAPITAL COSTS: ON-COSTS**

Basis of estimating: QSSD tender price index level ..... (Base 19 = 100)*
: PIPSH tender price index level ..... (Base 19 = 100)*

		Estimated Cost	Percentage of Departmental Cost
			%
1. Communication			
a. Space	£		
b. Lifts	£	£	
2. External Building Works			
a. Drainage	£		
b. Roads, paths, parking	£		
c. Site layout, walls, fencing, gates	£		
d. Builders work for engineering services outside buildings	£	£	
3. External Engineering Works			
a. Steam, condensate, heating, hot water and gas supply mains	£		
b. Cold water mains and storage	£		
c. Electricity mains, sub-stations, stand-by generating plant	£		
d. Calorifiers and associated plant	£		
e. Miscellaneous services	£	£	
4. Auxiliary Buildings		£	
5. Abnormals			
a. Building	£		
b. Engineering	£	£	
Total On-Costs to Summary (Form 1)		£	£

For use at Stage 1 and Stage 2
* Delete as appropriate
** Must be based on Scheme specific assessments/measurements; full breakdown of on-costs may not be available at Stage 1.
N.B. *Identify separately any proposed additional capital expenditure to improve specific aspects of scheme performance, e.g. energy saving measures.*

SCHEME ..... APPROVAL IN PRINCIPLE
BUDGET COST*

CAPITAL COSTS: FEES AND OTHER COSTS**

Basis of estimating: QSSD tender price index level ..... (Base 19 = 100)*
: PIPSH tender price index level ..... (Base 19 = 100)*

		Percentage of Works Cost %
1. Fees (including in-house costs)		
a. Architects	£	
b. Structural Engineers	£	
c. Mechanical Engineers	£	
d. Electrical Engineers	£	
e. Quantity Surveyors	£	
f. Project Managers	£	
g. Others	£ _____	
Total fees to Summary (Form 1)	£ _____	

2. Other Costs***
(specify items)

_____

Other Costs to Summary (Form 1) £ _____

For use at Stage 1 and Stage 2.
* Delete as appropriate.
** Full breakdown of fees may not be available at Stage 1.
*** Identify any preliminary works, enabling works and direct contracts.

SCHEME ..... APPROVAL IN PRINCIPLE
BUDGET COST*

REVENUE COSTS

Based on pay and prices at .....

Expected building opening date .....

Staff costs (to be related to staffing estimates)	£
Non-staff costs	£
Gross cost of scheme	£
Less consequential savings from closures	£
Net cost of scheme	£

Basis of estimate of non-staff costs

Forecast Revenue expenditure profile	Year	Amount £

For use at Stage 1 and Stage 2
* Delete as appropriate

Commercial - in confidence

CAPRICODE INFORMATION SHEET: CONCISE 1

AUTHORITY ..... N.I. CODE: .....

SCHEME: ..... INFORMATION VALID AT: .....

SECTION A

Capricode Stages	(i) Programmed dates Target	Actual	(ii) Works Cost or Equivalent (£)	(iii) Index	(iv) % On-Costs included in (ii)
(1) A.I.P.					
(2) Budget					
(3) Design					
(4) Tender					

Notes:

SECTION B

(1) Consultants	(i) Name	(ii) Fee as a percentage of Budget	Tender	Final Cost	(iii) Competitive (C) or Negotiated (N)
(a) Architect :					
(b) Structural Engineer :					
(c) Mechanical Engineer :					
(d) Electrical Engineer :					
(e) Quantity Surveyor :					
(f) Project Manager :					
(g) Others :					

(2) Type of Accommodation :
(3) Functional Content :
(4) Class of Work :
(5) Form/type of Construction :
(6) Project Funding: (a) Health % (b) University: % (c) Other: % Source:
(7) Certificate of Readiness to Proceed to Design: Stage 2B : Stage 3B
(8) Certificate of Readiness to Proceed to Tender:

SECTION C

(1) Contractors	(i) Name	(ii) Prime Cost Sums (£)	(iii) Unadjusted Main Tender	(iv) Adjusted Tender (£)
(a) Main Contractor :				
(b) Mechanical :				
(c) Electrical :				
(d) Lifts :				
(e) All other adjustments to the main contract				

(2) Tender date :
(3) Tender base date :
(4) QSSD Index of tender : (Base 19 = 100)
(5) Contingency sums in tender : £
(6) Contract dates : start :
complete :
(7)Form/type of contract :
(8) Fluctuating/Fixed Price :

(9) Approved Tender Sum : £
(10) Direct contracts, enabling works etc. : £
(11) Fees : £
(12) Equipment : £
(13) Overall cost at tender : £

Contact point: Name:
Phone:

Concise Reference:

Date:

See CONCISE 1 Users' Manual for instructions. DHSS HEALTH BUILDING DIRECTORATE

CAPRICODE PROCEDURES

Stage 1: Approval in Principle

Stage	Tasks/Main Activities	Documentation/ Guidance	Notes
1A. Inception	Review strategy and development priorities	Strategic Plans, Regional /District Reviews	
	Formulate service development proposals	Estatecode	
	Obtain option appraisal authorisation		
	Appoint Appraisal Team, allocate responsibilities		Identify accountable officer
	Prepare programme for Option Appraisal, target key dates		
1B Define Objectives, Constraints and Criteria for Development	Clearly define objectives for service development/improved performance	Option Appraisal guide for the National Health Service	Review plans for estate development/ rationalisation
	Identify any unavoidable constraints		
	Describe present activity, population served, resources and facilities used		
	Explain projected demand for services and justify assessments of functional content.		
	Assess potential for improving performance through better use of resources		Review Performance Indicators
	Confirm service development proposals and relate to policies and priorities as reviewed in Strategic Plans		
1C Consider and Appraise Options	Identify options. Consider, assess and evaluate relative costs and benefits of options		Liaise with the Authority responsible for Approval in Principle during stages 1C to 1E
			Consultants may be appointed to assist option appraisal
	Identify and evaluate alternatives for providing selected support and ancillary services, (e.g catering and laundry)		Use of Nucleus or other standard solutions must be considered
	Consult Community Health Councils and other local organisations affected		Consult relevant university on teaching hospital schemes (see Appendix 2)

Stage 1: Approval in Principle

Stage	Tasks/Main Activities	Documentation/ Guidance	Notes
1D Selection of Preferred Option	Select preferred option		
	Prepare Option Appraisal Report	Option Appraisal Report (Annex 1B)	
	- describe likely improvements in services and efficiency		
	- confirm proposals can be accommodated within the expected future revenue and capital budgets		
	- identify any changes of use, property closures and sales, provisionally update Estate records and Development Control Plans as necessary		Where Nucleus is not selected justify its rejection and explain reasons for proposed planning/design solutions
	- identify individual building scheme(s) and confirm provisional placing in capital programmes		AIP submission required for each individual building scheme
	Initiate Capricode Information Sheet: CONCISE 1	Annex 1D CONCISE 1 User's Manual	Required for schemes with Works Cost over £1m. Information Sheet capable of only partial completion at Stage 1
	Prepare AIP Submission	AIP Submission (Annex 1A)	Send submission to relevant university for information on teaching hospital schemes (see Appendix 2)
1E Approval in Principle	Formal acceptance of scheme in principle subject to :		The decision in principle must be documented and recorded
	- planning and design development confirming main service and resources objectives can be met		
	- continuing availability of capital and revenue resources for full implementation		
	- scheme continuing to offer best value for money in comparison with other options following review of AIP		
	Formal agreement to proceed to Stage 2		

Stage 2: BUDGET COST

General Notes

2.1 Throughout this stage the scheme option approved in principle is developed and the operational policies (whole hospital and the departmental policies) and associated planning, design and cost criteria that will govern subsequent work are confirmed in more detail. The objective is to establish criteria and prepare briefing that will allow the design team to develop an economical building solution of suitable form and content that promotes efficient and cost effective services.

2.2 Schemes must be planned and designed within the framework of an agreed Development Control Plan to take account of the expected pattern of services for the site/development as a whole.

2.3 The Budget Cost comprises separate cost limits (in real terms) for both capital costs and annual running costs. The cost limits provide an overall discipline for capital and running costs respectively. They are not intended to dictate rigidly the detailed design, operation and cost of individual departments. Whenever capital or running cost estimates are formally reviewed or updated at Stage 2, or during subsequent stages, the expected continued availability of resources should be confirmed.

2.4 Capital investment in selected support and ancillary services (e.g catering and laundry) must be validated in Budget Cost submissions.

Readiness to Proceed to Design

2.5 The 'Certificate of Readiness to Proceed to Design' (Annex 2B), signed by the Project Manager is required on all schemes of £½ million and over (Works Cost) at Stage 2B. A signed Certificate attests to the adequacy and integrity of the Scheme Brief in providing:

a. a firm statement of client requirements, and

b. all information necessary to proceed to completion of Stage 2 in accordance with the Management Control Plan.

Thus, consultant appointments may be made or confirmed on the basis of adequate knowledge of the scope of the scheme, the programme for development and the professional service required. This should ensure that design development will not be subject to uncontrolled change and disruption.

Capital Costs

2.6 The Capital Budget must be firmly based on or related to Cost Allowances. It is the basis of capital cost control throughout detailed design development and up to stage 4E when the Approved Sum is established. Adjustments may be made to reflect changes in Cost Allowances caused by building tender price movements and notified by the Department. The Capital Budget must not be exceeded unless there are sound demonstrable economic reasons for doing so.

2.7 On-cost elements must be closely controlled at all stages, initial estimates and any subsequent changes should be clearly explained and justified.

2.8 Authorities may plan to spend less than Cost Allowances provided function is not impaired, building and engineering standards are met (e.g. HBN, HTM standards), and running costs do not increase. If an authority can demonstrate, based on appraisal, that a scheme can be designed and built to enhanced standards which will lead directly to reduced running costs, then Cost Allowances may be exceeded. This will be acceptable only in the context of a scheme that is already efficiently and economically designed without exceeding Cost Allowances. Such enhancements must reduce the total present value of costs (present value capital costs plus present value running costs) and/or produce

identifiable and measurable increases in service benefits over the life of the scheme. Similarly specific enhancements to on-costs may be made in accordance with the provisions of this paragraph.

Revenue

2.9 The Revenue Budget should be based on the estimated running costs required to meet economically and effectively the expected demand for services. The estimates may be updated periodically to take account of movements, in real terms, of running cost components. As detailed operating and manpower arrangements are established and costed, revised estimates should be compared with the Revenue Budget and any significant changes explained and justified.

Review of Options

2.10 Key assumptions about the preferred option may change as better information emerges during Stage 2. Changes which could affect the viability of a scheme or bring other options into serious contention include;

a. the emergence of a new option which is clearly viable,

b. a real increase in capital costs or expected annual running costs, or changes in the availability of resources, e.g. a breach of trigger values attached to AIP capital cost and AIP revenue cost,

c. a reassessment of priorities and provision because of changes in the pattern of demand for health care or changes in methods of delivering services,

d. a review of regional/national policies and priorities,

e. changes in functional content affecting major departments or the strategic disposition of services, and

f. changes in scheme location/siting affecting patient/staff accessibility to services.

2.11 Where such changes occur, authorities will need to consider whether AIP should lapse. A decision to proceed with a scheme must be taken in consultation with the authority responsible for final AIP and must be clearly justified in the light of changed circumstances. Where a real increase in either capital costs or expected annual running costs exceeds a trigger value identified in the AIP Submission then AIP will lapse automatically. Where AIP lapses options must be reappraised and revised proposals submitted in accordance with Stage 1 procedures.

Procurement Method

2.12 Guidance on the arrangements for the procurement of building and engineering works is contained in CONCODE Part I. Chapter 1 advises on the use of various forms of contract and tender method. The choice of contract/procurement method should be made by the Project Manager in accordance with the Standing Orders/Instructions of the health authority. The decision should be based on the advice of the Senior Works Officers of the health authority. A 'Procurement Method Statement' must be prepared to justify and record the decision taken (see Chapter 4: Stage 4 Tender and Contract).

Budget Cost Submission

2.13 Budget Cost Submissions should be in the form outlined at Annex 2A.

2.14 A Budget Cost Submission should confirm that the preferred option remains best value for money and forms the basis of an effective and efficient building/service solution which conforms to relevant planning guidelines and Cost Allowances. There must be no subsequent changes in the overall form, content and real cost of the scheme as set out in the Budget

Cost Submission without specific approval in accordance with health authority Standing Orders/Instructions.

CONCISE

2.15 The CONCISE 1 Capricode Information Sheet required for all schemes with a Works Cost over £1 million must be updated on completion of Stage 2.

Procedures

2.16 The procedural stages up to and including Budget Cost Approval are outlined in Annex 2C.

BUDGET COST SUBMISSION

Budget Cost Submissions must contain the following information in the order shown. All work, including preliminary works, enabling works and direct contracts, necessary to bring planned facilities into use must be included.

1. TIMETABLE

Management Control Plan showing key dates (may be in the form of a network or bar chart).

2. SITE

Give any additional information about the site (e.g. soil conditions) which has become available since AIP.

3. FUNCTIONAL CONTENT

Confirm that the functional content is unchanged since AIP or detail changes giving reasons.

4. WHOLE HOSPITAL AND DEPARTMENTAL POLICIES

Describe general method of operation and any major departures from national guidance giving reasons.

5. DEVELOPMENT CONTROL PLAN/BUILDING SOLUTION

Briefly describe and give reasons for proposed building solution, attach site plan, block plans and sections as necessary to show main departmental relationships including relationships with existing facilities and any expected future changes as set out in the Development Control Plan.

6. CAPITAL COSTS

State Capital Budget and explain and justify:

a. costing of any function/service for which there is no cost allowance.

b. on-cost estimates.

c. costing for any additional measures to improve standards or reduce running costs etc. (clear demonstration of cost effectiveness based on appraisal required for justification).

State basis of estimating.

Use Annex 1C Cost Forms 1, 2, 3 and 4.

Validate investment in facilities for selected support and ancillary services (e.g. catering and laundry).

7. RUNNING COSTS

State annual Revenue Budget and estimated net running costs after taking into account savings from consequential rationalisation and closures. Reaffirm that any additional revenue required will be available. State basis of estimating. Use Annex 1C Cost Form 5.

8. COMPARISON WITH AIP

AIP must be reviewed when major changes occur. Key changes in service policies, service priorities, scheme content, capital/revenue costs, or the Development Control Plan should prompt such a review. Where changes undermine the continued viability of the scheme AIP should lapse.

Where a review of AIP is undertaken proper justification for continuing with the preferred option must be given.

N.B. *Increases which exceed a trigger value attached to either AIP capital cost or AIP revenue cost signal a review of AIP. AIP lapses automatically where increases in either AIP capital cost or AIP revenue cost exceed 10% in real terms. AIP lapses also where any changes to plans or content alter fundamentally the character and objectives of the scheme.*

9. PERFORMANCE

Identify expected improvements in performance and use of resources.

10. CONTRACT PROPOSALS

Describe proposals for contract/procurement method and length and value of contracts.

11. BUDGET COST STATEMENT

Attach Health Building Budget Cost Statement Annex 1C Cost Forms 1, 2, 3, 4 and 5.

CERTIFICATION OF READINESS TO PROCEED TO DESIGN: STAGE 2B/3B*

HEALTH AUTHORITY .....

SCHEME .....

Certification by Health Authority

1. The Authority is satisfied that the Scheme/Design* Brief dated ..... represents a comprehensive statement of client requirements at Stage 2/Stage 3* and covers all essential matters.
2. The Authority envisages making no changes to the Scheme/Design* Brief (excepting future changes in legal and statutory requirements).

Signed for and on behalf of the
Health Authority

.....

Date .....

Note: Health Authorities may adapt this form to obtain assurances on the adequacy and integrity of briefing from members of the Design Team.

* Delete according to Capricode Stage.

CAPRICODE PROCEDURES

Stage 2: Budget Cost

Stage	Tasks/Main Activities	Documentation/ Guidance	Notes
2A Scheme Brief	Appoint Project Team, allocate responsibilities		Identify Project Manager
	Prepare Scheme Brief for Design Team including :	Scheme Brief Design Briefing System	The Scheme Brief must be based on AIP criteria
	- description of functional content		
	- general statement on planning and operational policies		Design Team appointments may be made (CONCODE PART II CHAPTER 1)
	- Notional Cost Plan		
	- Management Control Plan		
	- draft schedules of accommodation		
	- other Scheme particulars (e.g. use of Nucleus system, energy performance)		
2B Readiness to Proceed to Design	Obtain assurances on adequacy and integrity of Scheme Brief	Certificate of Readiness to Proceed to Design	Required on schemes of £½m and over
2C Sketch Design	Establish outline building solution, scheme siting, form and shape	Block Plans/Sketch Designs Nucleus Design Data	
	- determine space and accommodation requirements of departments	Activity Data	Preliminary room data may be used
	- investigate site/survey existing buildings		
	- develop cost models and appraise siting, planning and design options	WKO(84)1 Integrated Energy Saving Design Options	
	- consider fire strategy	Draft HTM "Fire Safety - Health Buildings" September 1978 (to be superseded by HTM 81)	Separate high life risk areas from high fire load and high fire risk areas
	- prepare sketches of main departments and show departmental relationships		
	- identify scope and layout of principal environmental and engineering services installations and routes of site services		Where relevant initiate Nucleus Fire Precaution Approval Procedure
	- confirm availability of site and notify local planning authority	NHS Handbook on Land Transactions	

Stage 2: Budget Cost

Stage	Tasks/Main Activities	Documentation/ Guidance	Notes
2D Development Control Plan	Update and confirm Development Control Plan. - prepare block plan of scheme/project. - identify main departments and show relationship with any earlier development and possible future development	Development Control Plan. Development Control Planning Guide.	
2E Budget Cost	Update estimates of running costs (gross and net) and confirm basis of estimates Update estimates of capital costs and confirm basis of estimates - show breakdown of departmental cost, on-costs, professional fees/ in-house costs and equipment costs	Budget Cost Statement (Annex 2A)	Confirm level of university teaching contribution on teaching hospital schemes (see Appendix 2)
2F Procurement Method	Select procurement method Confirm estimated values of individual contracts	Procurement Method Statement. CONCODE - Part 1 Chapter 1	
2G Scheme Validation	Review AIP - consider any changes since Stage 1 - record and explain any agreed changes in service requirements, content, costs or location since AIP Confirm investment in selected support and ancillary services (e.g. catering and laundry) Confirm scheme can be accommodated within available capital and revenue resources		Review AIP at an earlier stage if important changes occur Where changes are not significant confirm approved option meets objectives, remains preferred choice and represents best value for money Where changes are significant (e.g. a real increase in either capital costs or annual running costs which breaches a trigger value identified in the AIP Submission) AIP will lapse automatically Where AIP lapses options must be reappraised and revised proposals submitted in accordance with Stage 1 procedures

Stage 2: Budget Cost

Stage	Tasks/Main Activities	Documentation/ Guidance	Notes
2G Scheme Validation (cont'd)	Confirm that building solution offers the prospect of a cost effective scheme providing for the efficient accommodation of identified services and functions		
	Confirm timetable for design, contract procurement, construction, commissioning and opening; identify key dates		
	Prepare Budget Cost Submission	Budget Cost Submission (see Annex 2A)	Send Budget Cost Submission to university for information on teaching hospital schemes (see Appendix 2)
	Update Capricode Information Sheet: CONCISE 1	Annex 1D	
2H Budget Cost Approval	Formal acceptance of building solution for scheme and agreement to proceed to Stage 3		Health authorities may delegate responsibility for Budget Cost Approval to designated Senior Officers who are indepedent of the Project Team

Stage 3: DESIGN

General Note

3.1 Stage 3 covers the detailed briefing of the Design Team, the design and cost planning of the scheme and the preparation of Production Information.

Design Brief

3.2 Multidisciplinary Project Teams responsible for preparing the Design Brief must include representatives who reflect the interests of those who will manage and operate the building and the services accommodated. The Design Brief must explain the basic programme, planning, operational and cost criteria established and approved at Stage 2, and must cover all essential design requirements. Aspects of the Design Brief may be clarified during design development and health authorities should be prepared to consider sensible solutions to design problems which modify aspects of the brief and which should produce a better overall scheme with improved operational efficiency. However, essential scheme guidelines, particularly concerning timetable, content and cost must not be modified unless overriding circumstances prevail and appropriate approval is obtained following a report detailing the consequences of the proposed change and the effects on programme and costs (including fees).

Readiness to Proceed to Design

3.3 A 'Certificate of Readiness to Proceed to Design' (Annex 2B) signed by the Project Manager is required on all schemes of £½ million and over (Works Cost) at Stage 3B. A signed Certificate attests to the adequacy and integrity of the Design Brief in providing:

a. a firm and detailed statement of client requirements, and

b. the information necessary for the Design Team to proceed to completion of Stage 3 in accordance with the Management Control Plan.

Planning Permission and Consultation

3.4 Before proceeding with development health authorities will consult local planning authorities when the proposed development is one for which, if the health authority were a private developer, local authority or statutory undertaker, planning permission would be required.

3.5 Certain aspects of development (e.g. boilerhouse chimneys, fuel supply, utility services) may require early consultation and detailed drawings which would not normally become available until the end of Stage 3. Late discussions with planning authorities and other organisations providing key facilities and services can cause difficulty in finalising designs and can disrupt programmes. Design Teams should recognise such potential difficulties and where possible order their programme of work and discussions with planning authorities etc. to ensure that all necessary consultations can be completed in good time.

Land Transactions

3.6 Arrangements for land acquisition/disposal must be properly co-ordinated with the requirements of planning and programming for schemes as reflected in Management Control Plans. Where relevant the Project Manager should liaise with others progressing land transactions and provide all information about the scheme needed to co-ordinate properly planning and development with any associated property acquisition/disposal. Rights of entry must be established before award of the building contract. The powers and duties of health authorities in carrying out individual land transactions are described in the National Health Service Handbook on Land Transactions.

Scheme Management

3.7 The Project Manager provides the channel of communication between the health authority and the Design Team (including the Supervising Officer) throughout Stage 3 and subsequent Stages. All instructions from the client to the Design Team (including instructions on commissioning matters) must be made or confirmed by the Project Manager.

3.8 Where a consultant Project Manager is commissioned, proper accountability to health authority management must be secured. The Supervising Officer and other members of the Design Team must be able to undertake their normal duties without diminution of their responsiblities under the building contract. The appointment of a consultant Project Manager should be made on the advice of the Senior Works Officer of the health authority. Guidance on the appointment of consultant Project Managers is given in CONCODE Part II Chapter 5.

Design Development

3.9 Stage 3 procedures should be applied interactively to promote the development of effective and efficient solutions. However, there must be a recognition that as the design is developed fundamental decisions made should not be overturned. Throughout Stage 3 the Design Team must prepare and submit to the health authority periodic Design/Cost Reports; production documentation must contain no surprises. Confirmation by officers of the health authority that design development accords with the Design Brief does not relieve the Design Team of their responsibility to produce a complete and integrated design solution that provides a satisfactory standard of accommodation.

Design Certification

3.10 Health authorities shall, by means of assurances from the Design Consultants, satisfy themselves that to the best of their knowledge and belief;

a. the design principles, the design calculations and drawings conform with Building Regulations and Codes of Practice including Health Service Fire Standards and British Standard specifications where appropriate,

b. calculations have been carried out correctly and reasonable care and diligence has been exercised in the development of the designs.

3.11 Assurances shall be obtained by the use of the appropriate certification forms (CONCODE Part II Chapter 1, Annexes C, D and E) and supplementary conditions to consultants' agreements (CONCODE Part II Chapters 2 and 3).

Readiness to Proceed to Tender

3.12 Before proceeding to Stage 4 health authorities must carry out pre-tender checks and seek from members of the Design Team assurances on the adequacy and integrity of the Production Information and adherence to the Works Cost. The health authority must be satisfied that the scheme can reasonably proceed to completion and commissioning without any foreseeable delay due to inappropriate and inadequately described requirements or insufficiently advanced design/production documentation or insufficient capital and revenue resources. The receipt of such assurances must be recorded in a Certificate of Readiness to Proceed to Tender (Annex 3A*). Where the Certificate is incomplete or qualified formal health authority approval is needed before tenders can be invited.

CONCISE

3.13 The CONCISE 1 Capricode Information Sheet required for all schemes with a Works Cost over £1 million must be updated on completion of Stage 3.

* Annex 3A may be adapted for signature by members of the Design Team.

Procedures

3.14 The procedural stages for scheme design are outlined in Annex 3B.

CERTIFICATE OF READINESS TO PROCEED TO TENDER

HEALTH AUTHORITY .....

SCHEME .....

1. The Authority is satisfied that this scheme has been prepared in accordance with Capricode procedures and that all reasonable steps have been taken to ensure that once the contract is let the scheme should be able to proceed to completion without delay. In particular the Authority is satisfied that

i. the Design Brief was frozen at the appropriate stage and will not be altered during the course of the contract other than in exceptional circumstances,

ii. the scheme has been designed within budget, and

iii. there are no causes of delay currently foreseeable.

2. Tender documentation etc. is consistent with, and fully reflects, the general production information to be provided to the Contractor. There is a feasible programme for the supply of any production material not available at tender stage, and the Authority has taken account of these factors in its assessment of the degree of readiness of the scheme.

3. The Authority has been assured by the Design Team and is satisfied that to the best of its knowledge and belief the design complies generally with The Building Regulations, and with Codes of Practice including Health Service Fire Standards and British Standards Specifications where appropriate. Appropriate Design Certificates have been obtained.

4. Capital and revenue resources will be available to build and commission the scheme according to programme and to operate the planned services.

Signed for and on behalf of the Health Authority

.....

Date .....

Note: Health authorities may adapt this form to obtain the necessary preceeding assurances from members of the Design Team.

CAPRICODE PROCEDURES

Stage 3: Design

Stage	Tasks/Main Activities	Documentation/ Guidance	Notes
3A Design Brief	Finalise detailed and agreed brief for design team use based on criteria approved at Stage 2	Design Brief Design Briefing System Nucleus Design Data	Design Brief must explain all essential requirements including operational, budgetary and technical commissioning matters
	- development objectives	Health Building Notes	
	- functional content		
	- whole scheme and departmental planning and operational policies (standard and scheme specific)		
	- notional cost plan and cost limit		
	- running cost limit/target		
	- Management Control Plan		
	- Development Control Plan		
	- planning constraints		
	- description of departments and schedules of accommodation		
	- outline sketch plans		
	- room data/layouts		
	- performance standards for building elements and engineering services		
	- structural fire precautions and means of escape		
	- major plant and equipment installations		Design Brief must not be changed after this point without clear justification and health authority approval.

Stage 3: Design

Stage	Tasks/Main Activities	Documentation/ Guidance	Notes
3B Readiness to Proceed to Design (re-affirmation)	Obtain assurances on adequacy and integrity of Design Brief	Certificate of Readiness to Proceed to Design	Required on schemes of £½ million and over
3C Design Development	Develop co-ordinated sketch designs including	Sketch Designs Cost Plan	
	- room data/layouts		
	- circulation and communication spaces		
	- engineering services	Health Building Notes	
		Nucleus Design Data and Costing Information	
		Equipment Notes	
	major plant and equipment installations	Health Technical Memoranda Activity Data	
	- equipment schedules		
	- specifications		
	- evaluate design options as part of cost planning (consider capital and running cost implications)		
	- cost plan/cost check design development		
	- consider detailed contract method, sub-contract arrangements and phasing		
	- confirm site access and contractors' areas		
	Prepare periodic progress reports on design development	Design/Cost Reports	Any real changes in the Works Cost must be included on updated Capricode Information Sheet: CONCISE 1
	Obtain assurance/confirmation that design development accords with Design Brief and adheres to Budget Cost		
	Identify any changes to Scheme design and/or cost since previous report		

Stage 3: Design

Stage	Tasks/Main Activities	Documentation/ Guidance	Notes
	Confirm co-ordination/integration of building and engineering services elements		
3D Detail Design	Progress and complete design work	Working/production drawings and documentation including: co-ordination drawings, specification, bills of quantities/schedules Health Building Notes, Equipment Notes, Technical Memoranda, Activity Data Base, Component Data Base	
	Update Capricode Information Sheet: CONCISE 1	Annex 1D	
3E Production Information	Confirm completion of Production Information	Production Information	
3F Pre-Tender Checks	Update capital and running cost estimates	Pre-Tender Estimate	PTE should be based on measurement and estimated at a known cost datum The Works Cost may be adjusted to reflect changes in Cost Allowances caused by building tender price movements and notified by the Department
	- reconcile with Works Cost		
	Obtain assurances on compliance with Building Regulations etc. and integrity of design calculations	Design Certificates CONCODE (Part II Chapter 1 para. 6.4, Annexes C, D and E)	
	- reconcile with Revenue Budget		
	Confirm that Production Information meets the essential requirements of the Design Brief	Final Design/Cost Report	

Stage 3: Design

Stage	Tasks/Main Activities	Documentation/ Guidance	Notes
3G Readiness to Proceed to Tender	Obtain assurances on completeness and integrity of design and Production Information	Certificate of Readiness to Proceed to Tender (Annex 3A)	Where the Certificate of Readiness is incomplete or qualified formal health authority approval is needed before tenders can be invited
	- demonstrate that resources will be available to build and operate the scheme		Possession of the site and rights and means of entry must be secure

Stage 4: TENDER AND CONTRACT

General Note

4.1 The objective at Stage 4 is to select a firm (or firms) to construct the scheme at a competitive price within the Works Cost.

Tendering/Contracting Arrangements

4.2 Health authorities should adopt tendering and contracting arrangements to suit the needs of individual schemes as set out in CONCODE (see CONCODE Part 1 Chapter 1 and paragraph 2.12 of this Procedures Manual). The decision should be based on the advice of the senior Works Officer of the health authority.

4.3 Best value for money will normally be obtained from selective competitive tendering with contract arrangements as recommended in CONCODE.

4.4 Tenders for sub-contract works should be invited before or concurrently with tenders for the main contract to permit assessment of the aggregated tenders against the Works Cost. Acceptance dates for sub-contract tenders should be properly co-ordinated with the programme for the main contract.

4.5 Where a contractor is appointed to participate in scheme planning and design (e.g. Design and Construct or Management Contracting) adaptation of the Capricode procedural sequence may be necessary. When adapting procedures, health authorities must adopt the underlying principles of Capricode and secure accountability by estabishing suitable arrangements for;

a. assessing the competence and capability of contractors in respect of planning and design (see CONCODE Part 1 Chapter 2),

b. confirming that design development accords with the Design Brief and adheres to the Budget Cost (where contractors assume responsibility for design),

c. seeking assurances on the adequacy and integrity of briefing, design and production documentation (vide Design Certificates and Certificate of Readiness to Proceed to Design and to Tender),

d. price competitiveness,

e. cost control and monitoring progress, and

f. funding capital and running costs.

4.6 Construction work executed under a management contract should not normally be commenced until sub-tenders for the work packages that are the main determinants of cost and critical to programme (i.e. substructure, superstructure, main engineering services) have been obtained and reconciled with the Works Cost to demonstrate adherence to the overall Budget Cost and the Management Control Plan.

Selection of Contractors

4.7 Health authorities must be assured of the financial viability, capability and capacity of contractors invited to tender for and undertake a scheme. Procedures for selection must be based on the guidance in CONCODE Part 1 Chapter 2.

Requirements of EC Directives

4.8 Where a scheme qualifies for advertisement in the Official Journal (OJ) of the European Communities, the OJ notice must be placed sufficiently early to meet prescribed time limits and to establish the financial and technical competence of respondents. Tenders cannot be invited until this process has been carried out. (see CONCODE Part 1 Chapter 2).

Tender and Contract

4.9 Tenders should not be invited until any necessary easements have been obtained and possession of the site and rights and means of entry for the contractor are certain.

4.10 Tenders must be received, considered and accepted in accordance with health authority Standing Orders/Instructions. Guidance on the arrangements for the invitation of tenders, their receipt and evaluation and the award of the contract is set out in CONCODE Part 1 Chapter 4.

Contract Period

4.11 Dates for the commencement and completion of the contract works must be established and these must reflect key dates included in the Management Control Plan. Suitable dates on the duration of the contract period may be laid down by the health authority and specified in the tender documents. Alternatively, tenderers may be asked to state, as part of their tenders, the period they would require for carrying out the works. Whichever method is used, actual dates should be agreed with the successful tenderer before the tender is formally accepted and the contract awarded.

4.12 When provided for under the conditions of contract, a detailed programme for the works should be obtained from the contractor as soon as possible after formal acceptance of his tender. In preparing the programme, the contractor should work in conjunction with any sub-contractors to be employed on the works whether selected by him or by the Supervising Officer.

Approved Sum

4.13 The establishment of an Approved Sum is a condition precedent to the award of any building contract. The Approved Sum should be based on accepted tenders and sub-tenders for all main scheme elements including mechanical and electrical installations and lifts. The Approved Sum must be reconciled with the Works Cost (which may be adjusted to reflect changes in Cost Allowances caused by building tender price movements and notified by the Department).

4.14 An Approved Sum must be established as detailed below;

a. where the lowest acceptable tender sum, adjusted for main sub-tenders, is on or below the Works Cost, health authorities may approve that sum and award the contract. Any saving on the Works Cost is not available for further work on the scheme,

b. where the lowest acceptable tender sum, adjusted for main sub-tenders exceeds the Works Cost by not more than 5%, savings should be sought and agreed with the successful tenderer before award of the contract to maintain the integrity of the Works Cost. If the excess is more than 5% proposals for achieving savings necessary together with a note of the effects of such savings (including their impact on the criteria underlying AIP) must be submitted to the authority who gave AIP for them to consider whether to proceed and on what basis.

4.15 Construction market conditions and the local tendering climate may produce an unexpectedly high tender level not anticipated by the Works Cost. In such circumstances an Approved Sum may be established which exceeds the Works Cost. Before giving such approval and awarding the contract, health authorities must be satisfied that;

a. the index level of the tender has been established and supports reconciliation with the Works Cost,

b. all reasonable savings have been achieved and agreed with the selected tenderer,

c. savings do not result in a loss of essential service/functional capacity or generate higher running costs,

d. a fresh competition or a competition at a later date (see CONCODE Part 1 Chapter 4 Paragraph 4.17) would be unlikely to produce an acceptable tender, and

e. resources needed to meet any excess will be available.

The substance of all savings and the reasons for establishing an approved sum which exceeds the Works Cost must be fully documented and available for audit.

Cost Analysis of Tender

4.16 An analysis of the accepted tender based on the 'CONCISE 3 Form of Cost Analysis for Health Building Work' must be prepared for all suitable schemes with a Works Cost of £1 million and over. The analysis of tenders for smaller schemes and the preparation of full departmental cost analyses is discretionary.

CONCISE

4.17 The CONCISE 1 Capricode Information Sheet required for all schemes with a Works Cost over £1 million must be completed on completion of Stage 4. Outstanding information relating to the award of principal sub-contracts must be entered as soon as it is available at Stage 5.

Procedures

4.18 Tender procedures leading to the establishment of an Approved Sum are outlined in Annex 4B.

CAPRICODE PROCEDURES

Stage 4: Tender

Stage	Tasks/Main Activities	Documentation/ Guidance	Notes
4A Select Tenderers	Advertise relevant schemes in Official Journal of the European Communities	See CONCODE Part 1 Chapter 2 for guidance and definition of relevant schemes	OJ advertisment should be placed during Stage 3 Design
	- select Tenderers		
4B Invite Tenders	Issue formal invitations and tender documentation	Approved list of contractors/ respondents to OJ advertisement	
4C Receive and Examine Tenders	Evaluate tenders and reconcile with Works Cost	Tender Report CONCODE (Part 1 Chapter 4)	
4D Establish Contract Programme	Agree dates for commencement and completion of works before acceptance of tender and award of contract		
	- reconcile key dates with Management Control Plan		
	- obtain detailed programme from contractor prepared in conjunction with sub-contractors (where provided under contract)		
4E Establish Approved Sum and Award Contract	Reconcile tender sum, adjusted for main sub-tenders and any negotiated post tender savings, with Works Cost	CONCODE (Part 1 Chapter 4)	
	- establish the Approved Sum		Notify relevant university of Approved Sum for teaching hospital schemes and confirm arrangements for payment of teaching contribution (see Appendix 2)
	- notify acceptance of tender		
	- enter into formal contract arrangements		

Stage 4: Tender

Stage	Tasks/Main Activities	Documentation/ Guidance	Notes
	- complete Capricode Information Sheet: CONCISE 1	Annex 1D	Capricode Information Sheet: CONCISE 1 completed at Stage 4 (Subject to later insertion of any outstanding information on main sub-contractors)
	- complete Brief form of Elemental Cost Analysis	CONCISE 3 Form of Cost Analysis for Health Building Work	Required for schemes with a Works Cost over £1m. CONCISE 3 input form included in Capricode Cost Control Guide

Stage 5: CONSTRUCTION

General Note

5.1 The aim at Stage 5 is to secure satisfactory completion of the Works on time and within the Approved Sum.

Contract Administration

5.2 The Supervising Officer is responsible for administering the contract conditions and for ascertaining and reporting on progress, quality and cost. Health authorities should confirm the Supervising Officer's responsibilities and establish arrangements for the maintenance of clear and effective communication and reporting through the Project Manager before work on site commences.

Contract Monitoring and Control

5.3 The progress of the Works, the incidence of contract payments (actual and predicted), and the effect and cost of any variation or claim authorised or anticipated must be closely monitored throughout construction. Early warning must be given of possible delays, escalation in cost and other difficulties in order that timely remedial action may be taken.

5.4 As part of health authority monitoring and control Capricode Contract Reports in the CONCISE 2 format at Annex 5A, must be prepared for all schemes with a Works Cost over £1 million. Capricode Contract Reports provide a summary of essential information on scheme progress and costs for the Project Manager, Project Team, health authority management and the Department. The reports must be prepared quarterly throughout the construction period to practical completion and biannually throughout the period of final account settlement to final completion. Lower value schemes must be closely monitored and controlled by Project Managers. Capricode Contract Reports and the CONCISE 2 system of monitoring may be applied to schemes with a Works Cost not exceeding £1 million at health authorities' discretion.

5.5 Normally the Project Manager will require the Supervising Officer to report formally at regular intervals in more detail and for some schemes, more frequently than provided by paragraph 5.4. These detailed reports may relate to any aspect of the Works, including progress, variations, claims, costs, incidence of expenditure (actual and predicted) and fluctuations. Where a significant departure from programme and/or cost is expected (e.g. a claim for extension of time or loss and expense, a serious failure to maintain programme, a breach of the Approved Sum) the Supervising Officer should report immediately to the Project Manager - without waiting for the next formal report - with a full explanation of the circumstances.

Approved Sum

5.6 The Approved Sum forms the basis of cost control throughout construction and until the Final Certificate is issued.

5.7 The cost of all construction work including main contract, direct contracts, enabling and preliminary works, necessary to bring the planned facilities into use must be contained within the Approved Sum. For the purposes of controlling an individual contract, a contract approved sum (i.e. excluding direct contracts etc) may be identified within the overall Approved Sum.

5.8 Authority may be given for increases to the Approved Sum where increased costs are justified. Requests for any increase must explain;

a. the initial Approved Sum and any increases previously approved,

b. the nature of the increases (e.g. variation category/claim) and the sum requested,

c. the underlying reasons for the increase,

d. what steps were considered to preserve the integrity of the Approved Sum, and

e. whether there has been prima facie a breakdown in control procedures (i.e. if earlier action had been taken could the increase have been avoided) and the corrective action being taken to prevent a recurrence.

Increases to Approved Sums shall be sought and made in accordance with health authority Standing Orders Instructions.

5.9 Certified fluctuations do not form part of the Approved Sum and must be reported separately on the Capricode Contract Report.

Variations

5.10 Variations to the Works can lead to serious delay and cost escalation; they should be avoided. Where a variation is justified and unavoidable the alternative ways of handling the work (e.g. by effecting the changes after practical completion) and the likely affects on programme and cost including claims, should be considered by the Design Team before a particular course of action is authorised. Variations outside the delegated powers of the Supervising Officer (e.g. limit on the cost and categories of variation which may be set against contingency sums) should be referred to the Project Manager for decision in accordance with delegated powers and other agreed procedures. Systematic arrangements should be established for obtaining quickly appropriate client authorisation before the contractor is instructed by the Supervising Officer to carry out varied work. Such arrangements shall not prejudice the responsibilities of the Supervising Officer under the contract and shall not relieve the Supervising Officer, the main contractor or sub-contractors of any of their contractual responsibilities.

5.11 The cost of variations shall be met from contingency sums (subject to the provision of parargraph 5.12) and/or authorised increases to the Approved Sum. Variations should be categorised under the following headings and reported in Capricode Contract Reports;

1. variations arising from a design change proposed or made by the Supervising Officer including rectifications of any mistake or omission in production information,

2. variations requested by the client,

3. variations arising from statutory or official policy changes,

4. adjustments to costs (normally for inflation) arising on the appointment of a nominated sub-contractor/supplier (PC sums adjustments),

5. adjustments to costs arising from expenditure of provisional sums and amounts for provisional quantities,

6. non-availability of specified items, and

7. miscellaneous and unallocated variations (e.g. outside the foregoing categories or which are awaiting a firm allocation).

Contingency Sums

5.12 Contingency sums are health authority resources provided in tender and contract documentation to cover the cost of unforeseeable work (i.e. contingencies) and other unforeseen work arising during construction. Contingency sums are included in the Approved Sum and may be expended only on the instructions of the Supervising Officer acting within the limits of his delegated authority (e.g limit on the cost and categories of variations which the Supervising Officer may set against contingency sums). The Project Manager must ensure that suitable arrangements exist for monitoring and managing expenditure of contingency sums. Any increase in contingency sums shall be treated as an increase to the Approved Sum and must be authorised accordingly. Contingency sums should not be expended on claims.

5.13 A breakdown of expenditure of contingency

sums (e.g. according to the appropriate categories in paragraph 5.11) must be maintained available for audit.

Dealing with Delay and Cost Escalation

5.14 The circumstances leading to serious programme delays, significant cost escalation or other major difficulties must be fully documented. Where such major departures and difficulties occur or are expected the Project Manager must consider with the Supervising Officer;

a. whether the integrity of the programme and the Approved Sum can be maintained through remedial action,

b. whether an extension of time and/or increase in cost is likely to arise under the contract, and

c. what corrective action is needed to prevent a recurrence.

5.15 Where delay occurs and the Supervising Officer does not issue a certificate giving extension of time, the contractor is under an obligation to make up any delay or become liable for liquidated damages. (see CONCODE Part 1, Chapter 6)

5.16 Where irrecoverable delay occurs, whether or not covered by extension of time, the Management Control Plan and budgeting arrangments must be updated accordingly.

5.17 Where the contractor is liable to pay liquidated damages notice must be given of any intention to claim or deduct liquidated damages before the Final Certificate is issued. Where liquidated damages are payable by the contractor the weekly amount payable and the total paid should be recorded in the comments section of the Capricode Contract Report.

Contractors' Claims

5.18 Where a claim is expected or has been made the Supervising Officer may not be able to determine its validity and likely cost consequences without extensive and detailed consideration. However, as soon as a claim is expected health authorities should consider estimated cost consequences. This procedure is without prejudice to the Supervising Officer's responsibilities under the building contract. Health authorities must not seek to influence the decisions of the Supervising Officer in these matters, nor to endorse those decisions either specifically or by implication. Where increased costs from claims arise an increase to the Approved Sum should be sought quickly in order that payment may be made to the contractor in accordance with the terms of the contract. It is a health authority's right and duty to require an explanation (including the reasons for the claim, the contract clauses under which it is made, any extensions of time with "relevant events", and a summary of the claim showing items of direct loss and expense and "list of matters") for any settlement the Supervising Officer proposes to make and to be satisfied (without prejudice to rights and resonsibilities under the contract) that any additional expenditure to which it is committed is justified (CONCODE Part 1 Chapter 5).

5.19 Claims which are valid under the contract should be ascertained as quickly as possible to facilitate prompt payment. Circumstances when interim ascertainments may be made are described in CONCODE Part 1 Chapter 5.

5.20 Wherever recourse to arbitration or litigation is contemplated or undertaken this must be noted in the comments section of the Capricode Contract Report.

Contract Payments

5.21 Treasurers' Departments responsible for making interim payments and final payment aris-

ing from the contract must be notified of conditions relating to payment (e.g. time limits) and must be fully informed on progress and cost including the forecast incidence of contract payments. It is a health authority's contractual duty to honour payment certificates issued by the Supervising Officer.

Final Account

5.22 The Supervising Officer should issue the final certificate within the prescribed period stated in the contract. Where this period is exceeded health authorities should stress the importance of a quick settlement under the contract of all outstanding matters.

5.23 Following practical completion the Capricode Contract Report should explain progress towards final account settlement, the progress on any outstanding claims and the anticipated final account figure.

5.24 All final accounts must be available for inspection and audit. To facilitate final account audit Treasurers' Departments must be notified when an interim final account is available and when the final account is agreed with the contractor. Final account audit cannot delay the issue of the Final Certificate under the contract.

Special Payments

5.25 Claims arising from building work which cannot be dealt with under the terms of the building contract (e.g. requests for ex-gratia payments) must be dealt with under the losses and special payments procedure (HC(78)42 and HC(80)3), which limits health authorities' powers to settle without Departmental authority (see CONCODE Part 1 Chapter 5).

Design Certificate on Completion

5.26 Health authorities shall, by means of assurances from the Design Team, satisfy themselves that to the best of their knowledge and belief the contractor has generally fulfilled his obligations with regard to the Building Regulations, Codes of Practice (including Health Service Fire Standards and British Standard Specifications) relevant in the design calculations and drawings subject to any approved variations.

5.27 Assurances, together with confirmation that approriate supporting documents have been obtained, shall be sought from the relevant Design Consultants using the certification forms in CONCODE (Part II Chapter 1, Annexes C, D and E).

Procedures

5.28 Procedures for construction are outlined in Annex 5B.

Commercial - in confidence

CAPRICODE CONTRACT REPORT : CONCISE 2

AUTHORITY: ..... REPORT NUMBER: .....

SCHEME : ..... N.I. CODE: ..... PERIOD ENDING: MARCH/JUNE/SEPT./DEC. 19 .....

SECTION A: PROGRESS

1. Original completion :
2. Original / Extended completion :
3. Expected/Practical completion :
4. Outstanding applications for extension of time : days

SECTION B: VARIATIONS

	Approved £	Anticipated £
1. Design team variations		
2. Client variations		
3. Statutory or official policy change		
4. PC sums adjustments		
5. Prov'l. Sums/Quantities adjustments		
6. Non-availability of specified items		
7. Miscellaneous and Unallocated		
TOTALS		

SECTION C: COSTS (excluding fluctuations)

1. Contract Costs excl. Direct Contracts
   a. Approved tender sum excl. contingency sums :
   b. Approved adjustment for Variations :
   c. Approved adjustment for Claims :
   d. Anticipated Variations :
   e. Balance of Notified Claims :
   f. Anticipated Claims :
   g. Balance of Contingency Sums :
2. Commitment excluding Direct Contracts :
3. Current Approved Sum excl. Direct Contracts :
4. Total Contingency Sums in Contract :
5. Current value of Direct Contracts, etc. :

COMMENTS AND ASSESSMENTS BY CLIENT HEALTH AUTHORITY

(use separate sheet for comments if necessary)

PROGRESS:

COSTS:

GENERAL STATE OF CONTRACT:

The Authority has taken all reasonable steps to ensure that it is fully informed of the state of the contract, and in the light of that information and the foregoing factors, the Authority considers the present state of the contract to be:

SATISFACTORY
UNSATISFACTORY
Delete as appropriate: if unsatisfactory please comment on action taken on separate sheet.

DECLARATION: Based on information available to the Authority and its agents this report is a full and true representation of costs and progress and the state of contract.

Signed for and on behalf of the Health Authority

SECTION D: EXPENDITURE SINCE LAST REPORT

a	b.	c	d	e	f	g
No of cert.	Date of Valuation dd/mm/yyyy	Cumulative value			Amount in column c for	
		* Contract Works £	Fluctuations £	Claims £	*Engineering Services £	x Estimated Variations £

* Before deducting retention and excluding fluctuations and claims

x Assessment of variations included in interim certificate

Contact point: Name:
Phone:

Concise Reference:

Date:

See CONCISE 2 Users' Manual for instructions. DHSS HEALTH BUILDING DIRECTORATE

CAPRICODE PROCEDURES

Stage 5: Construction

Stage	Tasks/Main Activities	Documentation/ Guidance	Notes
5A Construction Preparations	Confirm arrangements for administering the contract and monitoring progress		See Stage 6 for concurrent commissioning activities
	- hand over possession of site to main contractor		
5B Execution and Control of Works	Monitor progress of works and incidence of certified payments and maintain system of cost control		
	- monitor variations	Capricode Contract Report: CONCISE 2 CONCISE 2 Users Manual	Capricode Contract Report required quarterly on all schemes with a Works Cost over £1m
	- manage expenditure of contingency sums		
	- initiate management action where necessary to maintain programme and completion of works within Approved Sum		
	- prepare submissions for any increases to the Approved Sum, give necessary justifications and process submission in accordance with management requirements		Inform university of adjustments to Approved Sum affecting teaching contribution on teaching hospital schemes (see Appendix 2)
	- prepare full explanation for all ascertained claims	CONCODE (Part 1 Chapter 5)	
5C Completion of Works	Authorise Practical Completion Obtain design certification on completion	CONCODE (Part II Chapter 1)	
	- building handover		See Stage 6C
5D Final Account	Prepare final statement of account		Capricode Contract Report: CONCISE 2 required biannually from practical completion to final settlement and completion on all schemes with a Works Cost over £1m
	- final account settlement		
	- final account audit		

Stage 6: COMMISSIONING

General Notes

6.1 Commissioning a health building scheme requires that the operational criteria and policies on which the building design is based are put into practice to determine building performance and to provide for the effective and efficient operation of the health care services to be accommodated. It may be necessary to maintain continuity of essential services while any changes needed to bring a building scheme into use are effected.

6.2 Two main aspects of Commissioning may be identified;

a. technical commissioning of engineering and environmental services installations - normally carried out by the contractor under the terms of the building contract and part of the Project Manager's sphere of responsibility,

b. operational commissioning by the client covering the process of preparing for the commencement of patient services and the full and efficient operation of the health care facility - normally carried out under the management and supervision of the Commissioning Officer.

The chapter deals mainly with operational commissioning by the client and identifies key aspects of technical commissioning where appropriate.

6.3 Commissioning aspects will be a consideration during Stage 3 design and many Stage 6 activities will run concurrently with those carried out at Stage 5. Activities directly related to the opening of the scheme will normally commence when the main contract is awarded. The level of commissioning activity will intensify progressively as opening day approaches.

Commissioning Team

6.4 The Commissioning Team should comprise a core of senior staff and co-opted members representing those with responsibility for managing and running services. Responsibility for the management and implementation of operational commissioning, including consultation with staff, should be clearly vested in an individual, the Commissioning Officer, who should be accountable to management for co-ordinating and maintaining the programme of commissioning activities including liaison with the Project Manager to ensure proper co-ordination with the progress of building work.

Commissioning Brief

6.5 The Commissioning Brief is the operational concomitant of the Design Brief. The Design Brief provides essential guidelines for the preparation of the Commissioning Brief.

6.6 The Commissioning Brief should include:

a. a detailed commissioning programme that reflects;

i. the key dates in the Management Control Plan,

ii. the sequence and inter-dependence of activities (e.g. scheduling and delivery of equipment) and the time allowed for their completion, and

iii. the optimum timing of any consequential closures, transfers and decanting;

b. the Revenue Budget, broadly identifying the amounts allowed for main categories of spending including the funds allowed for commissioning activities themselves particularly the extra costs of starting up and establishing services;

c. the equipment costs element of the Capital Budget, and

d. the principal operational assumptions and policies that underlie the building design and layout, including relationships with other units and services.

6.7 While pursuing the implementation of the basic service and operational objectives of development within the Revenue Budget, the Commissioning Brief should not be drawn up so tightly that the exploitation of opportunities for improving services and efficiency and reducing costs may be frustrated. Any changes proposed which would contravene essential scheme guidelines, particularly timetable, content, level and quality of services and cost must not be implemented without approval being obtained following a full report detailing proposed changes and the effects on programme, building and operations.

6.8 A report on the actual incidence of equipment costs (showing the costs of equipping individual departments where appropriate) must be prepared and made available for audit on completion of commissioning.

6.9 The security and safety of empty premises must be maintained.

Operational Systems

6.10 The Commissioning Officer should be responsible for managing and co-ordinating the drawing up of operational systems and procedures covering the whole hospital or unit (e.g. communications, control of infection, financial control and budgeting, security, personnel and public relations) and individual constituent departments. The purpose is to set out how principal activities and departments will be operated taking account of necessary inter-relationships and the common services provided.

6.11 Operational systems must be developed from the operational policies on which the building design is based to promote the necessary compatibility between the built environment and the operation and delivery of services. As operational systems are developed there must be periodic checks on running cost consequences, carried out in conjunction with the Project Manager, to ensure that the hospital or unit can be operated within the Revenue Budget.

6.12 Operational systems should be documented to assist with initial staff training and trial or pilot running of services during the commissioning period. When services to patients have commenced operational systems may need to be modified in the light of practical experience to improve services, efficiency, and use of resources.

6.13 Procedure manuals, working practices and instructions for individual activities and departments, plant and equipment must be developed conjointly with operational systems.

Manpower

6.14 Manpower and personnel strategy and management will be the major determinant of the running costs and the effectiveness of services. Investment in new and improved accommodation provides a good opportunity to invest also in better methods of operating services.

Support Services

6.15 Where a scheme includes facilities for selected support and ancillary services (e.g. catering and laundry) a competitive tendering exercise should be undertaken to determine the most cost effective way of operating the facilities. Where accommodation for essential support services ia not included in a scheme (e.g. because their full provision by outside contractors is envisaged) arrangements to secure the provision of such services, including a competitive tendering exercise, must be made at an early enough point in planning to ensure that commissioning dates can be met. Sufficient time

must be allowed to make alternative arrangements in the event of competitive tendering not producing an acceptable offer.

Building Handover

6.16 It is the responsiblility of the Supervising Officer to determine that the Works are satisfactory and meet contract requirements before accepting the building and agreeing practical completion.

6.17 Arrangements for handover should provide for an orderly and comprehensive transition of responsiblities from the main contractor to the client health authority. A full set of "as built" record drawings must be provided by the Design Team together with operating and maintenance manuals and instructions for plant and equipment provided or installed under the building contract.

6.18 Throughout the defects liability period the Commissioning Officer in conjunction with the Project Manager should establish procedures for recording and reporting deficiencies, shrinkages or other faults to the Supervising Officer. Arrangements for the contractor to remedy defects should seek to minimise disruption to the commissioning programme.

6.19 Any building alterations necessary to ensure satisfactory completion of commissioning should wherever possible be carried out after practical completion of building work to avoid unnecessary disruption and delay to the contract works. The cost of such alterations, including work carried out under a separate contract, must be reported on Capricode Contract Reports: CONCISE 2 as part of the total cost of the scheme.

Procedures

6.20 Procedures for commissioning are outlined in Annex 6A.

CAPRICODE PROCEDURES

Stage 6: Commissioning

Stage	Tasks/Main Activities	Documentation/ Guidance	Notes
6A Commissioning Brief	Appoint Commissioning Team and allocate responsibilities		Identify Commissioning Officer
	Prepare Commissioning Brief	Commissioning Hospital Buildings - published by King Edward's Hospital Fund for London	Commissioning Brief must be operational concomitant of Design Brief
		Commissioning Brief	
	- prepare commissioning programme (include closures, decanting and transfers)	Design Briefing System	
		Nucleus Planning Principles and Design Description	
	- confirm Revenue Budget (including resources allowed for commissioning activities and the transfer/setting up of services)	Nucleus Whole Hospital Policies	Client health authority to authorise all substantive modifications which result in a change in content, an increase to the Approved Sum or revenue budget or delayed completion
	- confirm principle operation policies from Design Brief		
	- confirm any consequential closures/ transfers, carry out any residual consultations	HSC (IS) 207	
6B Commissioning Preparations	Develop Management/Operational Sytems for the efficient running of the building and the health services accommodated		
	- define services to be provided		
	- prepare workload estimates		
	- define organisational structure and lines of managerial responsiblity		
	- prepare operational handbooks (covering operations and maintenance)	Operational and Maintenance Handbooks	
	-prepare job specifications		

Stage 6: Commissioning

Stage	Tasks/Main Activities	Documentation/ Guidance	Notes
6B Commissioning Preparations (cont'd)	- invite competitive tenders for support services	HC(83)18	
	-select firms/organisations to provide support services (selection based on competitive tenders)		
	Consult staff		
	Establish manpower complement		
	- reconcile staff costs with Revenue Budget (include directly employed and contract staff) implement programme of staff training		
	- prepare and initiate programme for staff recruitment/ redeployment		
	Prepare equipment schedules	Activity Data Sheets Equipment Notes ECAG Equipment Schedules HTM 87	
	- reconcile equipment costs with capital budget		
	- prepare and initiate programme for ordering, receiving, storing and installing equipment		
	- establish systems for the management and operation of equipment	HEI 98	
	Prepare schedules of supplies and consumables		
	- prepare and initiate programme for ordering, storing and distributing supplies		
	Reconcile non-staff costs with Revenue Budget		
	Liaise with local services and organisations		
	-community health councils, local authorities, family practioner committees, adjacent health and ambulance authorities, fire authorities, voluntary organisations, public transport services etc.		

Stage 6: Commissioning

Stage	Tasks/Main Activities	Documentation/ Guidance	Notes
6C Building Handover	Test building elements and engineering services and plant	HTM 17 - Health Building Engineering Installations; commissioning and associated activities	Technical commissioning is normally contractor's responsibility under the building contract carried out before practical completion
	Authorise Practical Completion commence post-completion activities	Client receipt of building	
	Secure the building		Special attention must be given to fire precautions and means of escape
	Install and test equipment and report on equipment costs		HSE inspections may be required
	Report and remedy defects during defects liability period		
	Train staff		
	Trial implementation and co-ordination of main operational systems	HTM 83 Nucleus Fire Evacuation Strategy	Including fire evacuation drill
6D Building Opening	Arrange formal opening		The publicity of a formal opening ceremony is useful in bringing investment in new and improved facilities to the attention of the community served
	- prepare advance publicity and public relations - opening ceremony		
	- co-ordinate any consequential closures/transfers		Commissioing Team activity subsides and eventually ceases as departments and services become operational and unit management takes over

Stage 7: EVALUATION

General Note

7.1 Evaluation although identified as a discrete Capricode stage, should in practice be operated simultaneously with other stages through to final operation of the scheme when overall effectiveness can be assessed.

Process and Aims

7.2 Evaluation provides feedback for managers and designers to assist;

a. strengthening decision taking and management throughout the health building process, and

b. improving the design and the operation of health buildings.

Evaluation must seek to distil the experience gained and the lessons learned throughout the development process and during an initial period of operating services. Whenever important conclusions are drawn, evaluation information must be relayed back into the development process of other schemes. The aim must be to improve performance on future schemes by avoiding past mistakes and by replicating successes. Health authorities should identify an "Evaluation Focal Point" to ensure the timely consideration and dissemination of evaluation information as appropriate to Appraisal, Project, Design and Commissioning Teams and, where of major consequence, to the Department.

Evaluation During Scheme Development

7.3 Important lessons may be learned on planning, design, cost control, procurement etc. during the course of scheme development. Information could be of immediate value to the management and development of other schemes and should be passed quickly to the Evaluation Focal Point for dissemination.

Evaluation of Scheme in Operation

7.4 Many schemes, particularly those having a major impact on services, those which include innovation, and those likely to be replicated, will warrant a detailed evaluation of performance in use. This will normally take the form of a structured ex-post review to determine how far expected outcomes have been achieved, particularly the attainment of the original Stage 1 AIP objectives and performance aspirations. The exercise should be carried out once the scheme has become operational and systems and staff have had a chance to adjust to the new working environment. It is important that clear arrangements exist, via the Evaluation Focal Point, for disseminating the agreed conclusions of such evaluation exercises to those responsible for other schemes. The benefits of such evaluation may accrue both to schemes in the process of development and to schemes already in use where operational characteristics may be improved. Evaluation reports on schemes subject to Departmental Approval in Principle should be sent to the Department's Health Building Library.

Procedures

7.5 Procedures for Evaluation are outlined in Annex 7A.

CAPRICODE PROCEDURES

Stage 7: Evaluation

Stage	Tasks/Main Activities	Documentation/ Reference	Notes
7A Evaluation During Scheme Development	Identify important lessons in planning, design, cost control, procurement etc. which can be applied quickly to other schemes		An Evaluation Focal Point should be identified
7B Evaluation of Scheme in Operation	Review and report on scheme particularly the impact of accommodation and facilities on the operational effectiveness and efficiency of services: highlight performance in use including running costs. Review attainment of Stage 1 AIP objectives	Health Buildings Evaluation Manual	

SUMMARY OF CAPRICODE STAGES

Stage 1 Approval in Principle
- 1A Inception
- 1B Define Objectives Constraints and Criteria for Development
- 1C Consider and Appraise Options
- 1D Selection of Preferred Option
- 1E Approval in Principle

Stage 2 Budget Cost
- 2A Scheme Brief
- 2B Readiness to Proceed to Design
- 2C Sketch Design
- 2D Development Control Plan
- 2E Budget Cost
- 2F Procurement Method
- 2G Scheme Validation
- 2H Budget Cost Approval

Stage 3 Design
- 3A Design Brief
- 3B Readiness to Proceed to Design (re-affirmation)
- 3C Design Development
- 3D Detail Design
- 3E Production Information
- 3F Pre-Tender Checks
- 3G Readiness to Proceed to Tender

Stage 4 Tender
- 4A Select Tenderers
- 4B Invite Tenders
- 4C Receive and Examine Tenders
- 4D Establish Contract Programme
- 4E Establish Approved Sum and Award Contract

Stage 5 Construction
- 5A Construction Preparations
- 5B Execution and Control of Works
- 5C Completion of Works
- 5D Final Account

Stage 6 Commissioning
- 6A Commissioning Brief
- 6B Commissioning Preparations
- 6C Building Handover
- 6D Building Opening

Stage 7 Evaluation
- 7A Evaluation During Scheme Development
- 7B Evaluation of Scheme in Operation

SCHEMES SHARED WITH THE UGC/UNIVERSITIES

1. Universities will share the capital cost of schemes containing a teaching and research element. Provision of university teaching/academic space in a teaching hospital scheme will be related to the size of the medical school and the disposition of accommodation for students. An agreed assessment of teaching/academic space in relation to the scheme as a whole will provide the basis for calculating the teaching contribution to capital costs. Where the university's share is eligible for UGC capital funding the university must notify the UGC at an early point in planning, usually at Stage 1 AIP, to ensure the necessary financial arrangements can be made. Guidance on the assessment of the proportion of teaching/academic space is published by the Department (DS 65/74). Close collaboration between university and health authority is essential at all stages of shared schemes.

2. Where appropriate health authorities must consult with the university at Stage 1 AIP to identify the teaching/academic element of schemes and to estimate the teaching contribution. The AIP Submission should be sent to the university for information and notification of AIP given.

3. At Stage 2 Budget Cost the teaching/academic element and the level of the teaching contribution should be confirmed and the likely incidence of payments from the university to the health authority should be established. The Budget Cost Submission must be sent to the university for information.

4. Health authorities should notify the university of the Approved Sum established at Stage 4E and confirm arrangements for claiming reimbursement of the teaching contribution (see HN (83) 17).

5. Health authorities should ensure that accounts for the reimbursement of the teaching contribution are submitted promptly as work proceeds. Fluctuations as they arise under the building contract must be apportioned to the teaching contribution and included in claims for reimbursement. The university should be informed of any adjustments to the Approved Sum that will affect the teaching contribution.

GLOSSARY

Capricode terminology should be interpreted as follows:

Abnormals
Exeptional or ad-hoc factors, usually arising from site difficulties and constraints which increase capital costs, (for example, demolitions, adverse soil conditions, poor bearing capacity of ground works or alterations to existing buildings). The cost of dealing with abnormals are part of the on-costs of schemes.

Activity Data
Information sheets describing:
a. tasks and activities performed in health buildings and having planning significance;
b. environmental and spatial requirements, and
c. the equipment and engineering terminals required.
Activity Data Sheets are issued to RHAs; they are not on general sale.

Ad-Hoc Department
Health building departments without a Health Building Note and associated Cost Allowance.

Approved Sum
The overall capital sum for construction work on a scheme (including main contract, enabling and preliminary works necessary to bring planned facilities into use) approved by the client health authority at stage 4E on the basis of tenders received or prices negotiated. Once the contract is let the Approved Sum should not be increased without further fresh approval obtained in accordance with health authority Standing Orders/Instructions. The Approved Sum is exclusive of fluctuations allowable under the contract and Value Added Tax.

Appraisal Team
A small multi-disciplinary team of health authority officers (with selective support from consultants where appropriate) responsible for the appraisal of options and the AIP Submission at Stage 1.

Block Plan
A plan (usually 1:500 scale) showing the broad outline of an existing or proposed building. Building content, functions accommodated and main communications will usually be identified.

Budget Cost
An estimated cost limit, normally expressed in real terms, of the overall capital costs and annual running costs of a scheme (Capital Budget and Revenue Budget shown separately). A Budget Cost must be approved by the client health authority at Stage 2H. Thereafter the capital and revenue components are used as a basis for controlling scheme design and development. The Capital Budget is superseded by the Approved Sum established at Stage 4E. Scheme budget costs should be linked to agreed levels of building and service provision. The capital and running cost components of the Budget Cost must be reported at a known cost datum; capital costs may be adjusted to reflect changes in Cost Allowances caused by building tender price and equipment price movements and notified by the Department. Running costs may be adjusted to reflect agreed movements in the price of running cost factors. All real increases to the Budget Cost must be justified and approved.

Building and Engineering Cost
See Works Cost.

Capital Budget
The capital costs component of the Budget Cost.

Circulation Space
Space within a department for movement of people and supplies (also includes space occupied by internal partitions).

Claim
Any unsolicited request by the contractor or sub-contractor for monies not provided for in the contract sum arising either within or outside the terms of the contract, which may or may not be recognised as justifiable by the Supervising Officer.

Commissioning Brief
The operational concomitant to the Design Brief, containing the essential operational/implementation, programming and budgeting requirements for bringing a scheme into operation.

Commissioning Officer
The individual responsible for the overall management, supervision and co-ordination of commissioning by the client who is accountable to health authority management.

Commissioning Team
A team comprising a core of officers responsible to the Commissioning Officer, and concerned with the management and supervision of commissioning by the client necessary to bring schemes into effective and efficient operation. Representatives of those responsible for managing and running services may be co-opted into the Commissioning Team.

Communications
Space and/or main engineering services between departments for movement of people supplies and services (including lifts, stairs and main ducts or shafts).

Consultants
Construction consultants appointed to assist the planning and design of a scheme and the supervision of its construction as agents of the client health authority. The Supervising Officer is a Consultant with particular additional responsibilities under the building contract.

Contingencies
Unforeseeable circumstances requiring work occurring during the contract period, e.g. flooding caused by exceptional heavy rain. Contingencies are treated as a variation of the contract work, and associated costs should be recorded under variation category (7) paragraph 5.11.

Contingency Sums
Sums included in tenders and incorporated into the Approved Sum which may be allocated to cover the costs of unforeseeable work (i.e. contingencies) and other unforeseen work that may arise during construction. Contingency sums will not normally be expended on Design Team variations and client variations (variation categories 1 and 2 paragraph 5.11).

Contract Approved Sum
The sum established within the overall Approved Sum for the purposes of controlling an individual building contract forming part of a scheme. The Contract Approved Sum must be managed with and in the same way as the Approved Sum. The Contract Approved Sum is not necessarily the same amount as the Contract Sum forming part of the building contract.

Cost Allowance (DHSS Cost Allowance)
The maximum capital sum normally allowable for the provision of a defined amount of functional accommodation. Cost allowances are promulgated by the Department. Cost Allowance may be exceeded only where an investment appraisal has demonstrated that within the context of an economical and efficient overall design further running cost savings and/or measurable service benefits may be obtained from the increased capital provision.

Defects Liability Period
The period of time stated in the contract and starting from the date of practical completion of the works, during which the contractor is liable for making good defects attributable to workmanship or materials not having been in accordance with the contract.

Departmental Cost
The capital sum allowed for functional provision based on (or derived from) Cost Allowances. Where Cost Allowances are not appropriate the costs for individual departments should be justified on the basis of similar accommodation in other schemes.

Design Brief
A document compiled by the Project Team and ratified by the Project Manager containing instruction to the Design Team stating the essential detailed requirement of the client (particularly accommodation, programme, planning, operational and cost requirements) that the scheme must meet.

Design Briefing System (DBS)
A series of documents used in conjunction with new or revised Health Building Notes (HBN) to assist the specification of user requirements for the Design Brief. Each document adopts a check list approach providing a framework which guides the Project Team through consideration of organisational and planning options leading to the selection of activity spaces. A companion DBS is issued to health authorities with the advance copy of each HBN.

Design/Cost Reports
Reports on design development and cost consequences to demonstrate fulfillment of the Design Brief and adherence to the Budget Cost. Costs must be reported at a known cost datum.

Design Team
A team comprising consultants/health authority design staff responsible for scheme design and the supervision of its construction and the settlement of accounts.

Development Control Plan
A series of drawings comprising site plans with contours, (or spot heights) schematic plans and sections of buildings, showing existing properties and proposed cycle of site development, identifying individual schemes, outline of engineering service networks, functional relationships and main communications within and between buildings. The Development Control Plan should not pre-empt the appraisal of Options at Stage 1 and may be revised as a consequence of the scheme approved in principle.

Equipment
Equipment is classified into four groups:
Group 1 Items usually supplied and fixed by the contractor.
Group 2 Items, having a significant effect on space or structural requirements, which are supplied by the health authority and fixed by the contractor.
Group 3 Items, having a significant effect on space or structural requirements, which are supplied by the health authority and put in position by them or their agents outside the general contract.
Group 4 Smaller items, usually storage items, supplied and put in position by the health authority.

Equipment Costs
Costs, usually incurred outside the building contract (and hence not forming part of the Works Cost), related to the supply of Group 2 equipment, supply and installation of Group 3 equipment, and supply and placing in position of Group 4 equipment.

External Works
Building and engineering works external to the outer wall of the building but forming an integral part of the scheme, and main engineering supply services internal to the building but outside the confines of individual departments. External Works are part of scheme on-costs.

Fluctuations
Net increases or decreases in costs and other defined expenses which are admissable under the contract and are paid to or allowed by the contractor.

Functional Content
The service/departmental capacity of a health building scheme expressed in terms of functional units.

Functional Unit
A unit for measuring the capacity of health building accommodation in terms of service related content. For example, the functional unit for measuring the capacity of wards is the bed.

Health Building Notes (HBNs)
Health Building Notes set out the standards of accommodation and environmental services for health buildings which the DHSS, in consultation with the NHS, recommends. HBNs are published for the majority of health building departments and may be purchased from HMSO bookshops.

Health Technical Memoranda (HTMs)
HTMs are publications which give guidance on specific health building subjects, mainly in the field of engineering standards, safety standards, etc. HTMs relate usually to health buildings and associated environmental systems as a whole rather than to individual departments. HTMs are published by HMSO.

Management Control Plan
The overall programme and plan of work for the execution and commissioning of a scheme. The plan must take account of Capricode activities and a scheme's requirements in terms of resources and timing. It will normally be expressed in diagrammatic form (network or bar chart) and will be updated regularly to reflect progress made.

Notional Cost Plan
A statement of preliminary proposals for the broad allocation of capital cost to the main elements in a scheme. The notional cost plan provides for a proper balance between elements, it should be produced for each individual building and overall cost must not exceed, in real terms, the Works Cost included in Budget Cost Approval. Notional cost plans are included in the Design Brief.

On-Costs
Capital costs arising from the interaction of the building and its site, (for example the cost of communications between departments, external works, and services, additional energy saving measures, auxiliary buildings and abnormals).

Operational Policy
A statement outlining the objectives, principal functions and principal operational characteristics of a health building scheme, a hospital department or a particular service/activity.

Operational Systems
A description of the way a health building scheme, a hospital department or a particular service/activity will operate within prevailing spatial and resource constraints. Operational systems must take account of the interdependent nature of services and activities and should clarify managerial responsibilities.

Pre-Tender Estimate
An assessment of the anticipated capital and running costs of a scheme based on the bills of quantities and other production documentation and an updated assessment of operational aspects and manpower requirements. Estimates should be at a known cost datum and must be prepared before tenders are invited.

Procurement Method Statement
A statement of the proposed form of contract and the arrangements for executing design and construction, selecting consultants and contractors, and establishing the contract price. Reasons for adopting the selected procurement method must be included.

Production Information
The drawings, specifications, schedules and bills of quantities needed for tendering and construction of the building and its services.

Project
The complete cycle of development work envisaged for an individual hospital or health service site. A project may include a number of building schemes.

Project Manager
The individual responsible for the overall management of a scheme, particularly adherence to budget and programme, who is accountable to health authority management. A Project Manager may be either an officer of the health authority having overall management responsibility for a scheme (normally the individual who would lead the Project Team) or a consultant Project Manager from the private sector selected and commissioned to manage a particular scheme.

Project Team
A small multidisciplinary team of health authority officers (with selective support from consultants where appropriate), normally responsible to the Project Manager, concerned with management, cost and progress of a scheme at Stages 2, 3, 4 and 5, and for technical commissioning at Stage 6. The Project Team through the Project Manager will be responsible for generally safeguarding the client's interests. Team membership shall be reviewed on completion of each stage and if necessary re-cast to reflect the work and activities of the next stage. For small capital schemes a single officer/manager with the power to co-opt advice from others if a particular issue arises may carry out the functions of the Project Team.

Revenue Budget
The running costs component of the Budget Cost.

Scheme
All planning, design and construction work and commissioning activity necessary to bring planned facilities into use (including essential preliminary and enabling works).

Scheme Brief
A document prepared at Stage 2 by the Project Team which outlines general requirements for the approved scheme including content, accommodation, location, planning considerations and programme for development etc.

Supervising Officer
The consultant, normally an Architect, with particular additional responsibilities for administering the building contract and the inspection of the Works.

Tender Sum
The lowest acceptable sum tendered in competition or established in negotiation or obtained through single tender action.

Works Cost
The overall departmental cost allowed for a scheme plus on-costs (includes group 1 equipment and fixing of group 2 equipment). Sometimes known as "building and engineering cost".

ABBREVIATIONS

ADB	- Activity Data Base
AIP	- Approval in principle
BQ	- Bills of Quantities
CDB	- Component Data Base
CHC	- Community Health Council
DHA	- District Health Authority
DHSS	- Department of Health and Social Security
EC	- European Community
ECAG	- Equipment Cost Allowance Guide
EN	- Equipment Note
HEI	-Health Equipment Information
HC	- Health Circular
HMSO	- Her Majesty's Stationery Office
HSC	- Health Service Circular
HSE	- Health and Safety Executive
HTM	- Health Technical Memorandum
ITP	- Index of Tender Prices
JCT	- Joint Contracts Tribunal
NHS	- National Health Service
NI Code	- NHS Institution Code
OJ	- Official Journal of the European Communities
PAC	- House of Commons Committee of Public Accounts
PC Sum	- Prime Cost Sum
PIPSH	- Price Index of Public Sector Housing
PTE	- Pre-Tender Estimate

QSSD	- Quantity Surveying Services Division (Department of the Environment)
RHA	- Regional Health Authority
SHA	- Special Health Authority
SI	- Statutory Instrument
SO	- Supervising Officer under the contract
UGC	- University Grants Committee
UK	- United Kingdom

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